

**A Critical Evaluation of the Involvement of Pastors with Mental Patients:
A Case Study of Saint John of God Mental Hospital in Mzuzu, Malawi**

By

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Declaration

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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Abstract

This study critically evaluates pastors' involvement in the treatment of people suffering from mental illness at Saint John of God Mental Hospital, a community based mental health mission run by the Roman Catholic Church, in Mzuzu, Malawi. The problem that this study investigates is the exclusion of non-Catholic pastors from the healing ministry of people with mental illness. This exclusion often leads to the relapse of mentally ill people when they (or their guardians) seek the services of pastors once they are discharged from hospital and are advised to stop medication in favor of healing through faith and prayer.

This study draws inspiration from my experience as the Pastoral Care Coordinator at Saint John of God Mental Hospital, which has led me to discover that most patients, once they are discharged, turn to pastors who have no experience in the treatment of mental illness, a decision which often has tragic results. The patients are instructed to stop medication after the pastors pray for them. Such instructions led to patients' relapse and readmission to the hospital or in worse scenarios, their suicide.

This study considers the possibility of including pastors of other denominations in caring for patients at Saint John of God Mental Hospital. To conduct the evaluation, the study utilizes a practical theological methodology as proposed by Richard Osmer (2008) and the chapters are structured and aligned with the four tasks of practical theology that he identifies. It also makes use of related literature in theology, health and other social sciences. As such, the first chapter focuses on the African epistemology on illness and healing. It further discusses the African Synod's endorsement of inculturation as a vital component of evangelisation. Chapter One presents a discussion of liberation (feminist) theology with the aim of giving a voice to patients suffering from mental illness. The second chapter evaluates the Curia, Provincial and the Malawian Pastoral Care policy documents in order to discuss the burden of relapse as a result of the exclusion of pastors from other denominations from the healing ministry. Chapter Three is a historical discussion of the contribution made by pastors to the healing of patients in hospital. Following on from that, Chapter Four proposes possible ways in which to include pastors from other denominations in mental health healing at St. John of God Mental Hospital.

Overall, the evaluation of the policy documents indicates that the Malawian policy on pastoral care is inconsistent with the African understanding of illness and healing, the Roman Catholic Church's view on inculturation and the overarching Curia and Provincial policy documents. The study furthermore argues that the exclusion of pastors from other denominations adds to the burden carried by mentally ill patients and their guardians. For this reason, it establishes the need for a holistic and multifaceted approach that can respond to the needs of mental patients in the hospital. Ultimately, it recommends that Saint John of God Mental Hospital finds a way to responsibly involve pastors from other denominations in its healing ministry in order to achieve sustainable and holistic healing.

Opsomming

Hierdie studie is 'n kritiese evaluering van die moontlike betrokkenheid van pastors van ander denominasies as die Rooms Katolieke Kerk, by die bediening aan pasiënte met geestesongesteldhede in Saint John of God Mental Hospital in Mzuzu, Malawi. Die probleem wat hierdie studie ondersoek, is die huidige beleid wat die pastorale sorg van pastors van ander denominasies uitsluit. Ditlei dikwels tot terugslae of weerinsinkings van mense met geestesongesteldhede wanneer hulle ontslaan word en hulle (of hul voogde) die dienste van pastors benodig. Hierdie navorsing volg op my ervarings as die Pastorale Sorg Koördineerder van Saint John of God Mental Hospital, waar ek ontdek het dat die meeste pasiënte na ontslag deur hul plaaslike kerkleiers aangeraai word om medikasie te staak en eerder staat te maak op geloofsgenesing-sessies waar daar vir hulle gebed word. Hierdie aanbevelings van pastors wat die gebruik van medikasie teenstaan, lei daartoe dat pasiënte terugsink en hertoelating tot die hospitaal moet kry, of, in die ergste gevalle, selfmoord pleeg.

Die navorsing oorweeg die moontlikheid om pastors van ander denominasies in te sluit by die pastorale sorg van pasiënte by Saint John of God Mental Hospital. Die studie maak gebruik van 'n praktiese teologiese metodologie soos voorgestel deur Richard Osmer (2008) en die hoofstukke van die navorsing is gestruktureer en belyn volgens Osmer se vier take van praktiese teologie. Die navorsing maak ook gebruik van teologiese, gesondheids- en geesteswetenskaplike literatuur. Die eerste hoofstuk fokus op die Afrika-epistemologie van siekte en genesing. Dit bespreek die Rooms Katolieke Kerk se Afrika-Sinode se konsep van inkulturasie as 'n noodsaaklike komponent van evangelisasie. Hoofstuk Een sluit ook in 'n voorlegging oor bevrydings- (feministiese) teologie met die doel om 'n stem te gee aan pasiënte met geestesongesteldhede. Hoofstuk Twee evalueer die Curia-, Provinsiale en Malawiese Pastorale Sorg beleidsdokumente. Die hoofstuk bespreek ook die las van pasiënte wat weerinsinkings beleef as gevolg van die uitsluiting van pastore van ander denominasies in die genesingsbediening. Hoofstuk Drie is 'n geskiedkundige bespreking van die bydrae van pastors tot die genesing van pasiënte in die hospitaal. Hoofstuk Vier stel verskillende maniere voor waarop pastors van ander denominasies ingesluit kan word by die genesing van geestesgesondheid by Saint John of God Mental Hospital, waar die huidige beleid nie pastors van ander denominasies as die Rooms Katolieke Kerk by die bediening van genesing insluit nie.

Die evaluering van die beleidsdokumente dui aan dat die Malawiese beleid oor Pastorale Sorg teenstrydig is met die Afrika verstaan van siekte en genesing, die Rooms Katolieke Kerk se beleid oor inkulturasie, en die Curia- en Provinsiale beleidsdokumente. Die studie argumenteer dat die uitsluiting van pastors van ander denominasies, 'n groter las op pasiënte en hul voogde plaas. Die navorsing bevestig die noodsaaklikheid van 'n holistiese en veelsydige benadering en respons tot pasiënte met geestesongesteldhede in die hospitaal. Die studie beveel aan dat Saint John of God Mental Hospital 'n manier vind om pastors van ander denominasies ook by die bediening van genesing te betrek om volhoubare en holistiese genesing te verseker.

Dedication

I dedicate this thesis to those struggling with mental illness who, in working with them, have shaped my outlook to life. I also dedicate it to my mum, who insisted on the need of getting educated though dad died when I was only ten years old. To Peter Wells and Lily (late) in the UK for their untiring support towards my life and our family. To my family members and my upcoming generation of children who will see that life gives a lot of possibilities. Being the first person to obtain a Master's Degree, I have just opened such possibilities. They will do more than what this reality will present to them.

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Abbreviation and Acronyms

ACPE:	Association for Clinical Pastoral Education
AIC:	African Initiated Churches
AIDS:	Acquired Immune Deficiency Syndrome
APA:	American Psychiatric Association
APC:	Association of Professional Chaplains
AU:	African Union
CAPPE:	Canadian Association for Pastoral Practice and Education
CCC:	Catechism of the Catholic Church
CCU:	Consultation on Church Union
CHAM:	Christian Health Association of Malawi
CMA:	Community Midwifery Assistants
COMESA:	Common Market of Eastern and Southern Africa
CPD:	Continuous Professional Development
CPE:	Clinical Pastoral Education
DNA:	Deoxyribonucleic Acid
DSM-V:	Diagnostic and Statistical Manual of Mental Disorders
ECT:	Electroconvulsive Therapy
EPHS:	Essential Package of Health Services
FBO:	Faith Based Organisation
GCCME:	Geneva Convention Code of Medical Ethics
HDIR:	Human Development Index Report
HIV:	Human Immunodeficiency Virus
HOH:	House of Hospitality

HPC:	Health Professional Council
ICD:	International Classification of Diseases
IVT:	Institute for Vocational Training
KCN:	Kamuzu College of Nursing
MDG:	Millennium Development Goal
MDGE:	Malawi Development Goals Endline Survey
MDHS:	Malawi Demographic and Health Survey
MHSSP:	Malawi Health Sector Strategic Plan
MOH:	Ministry of Health
NACC:	National Association of Catholic Chaplains
NCD:	Non-Communicable Diseases
NCHE:	National Council of Higher Education
NGO:	Non-Governmental Organisation
O.H:	Hospitaller Order of Saint John of God
PCC:	Pastoral Care Coordinator
PHC:	Primary Health Care
RCC:	Roman Catholic Church
SADC:	Southern Africa Development Community
SDA:	Seventh Day Adventist
SDG:	Sustainable Development Goals
SJOGCOHS:	Saint John of God College of Health Sciences
SLA:	Service Level Agreement
TBA:	Traditional Birth Attendants
UNDP:	United Nations Development Program

UNDP:	United Nations Development Program
USA:	United States of America
WHO:	World Health Organisation
WIC:	Western Initiated Churches

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CHAPTER ONE

INTRODUCTION TO THE RESEARCH

1.1. Background of and Motivation for the Study

The motivation for this study stems from my experience as an employee of Saint John of God Mental hospital where I have worked as the Pastoral Care Coordinator since 2011. Throughout the eight years that I have worked at this institution, I have been providing and facilitating pastoral care services to patients suffering from mental illness, both during the time they are in the hospital and through routine follow-up visits once they are discharged. The Pastoral Care Coordinator office is mandated to organise and facilitate all prayers in the hospital. Additionally, the Pastoral Care Coordinator is supposed to be a member of the Roman Catholic Church (RCC). The hospital has a policy that restricts anyone but the hospital's own Catholic chaplain or another Catholic priest from conducting prayers in the hospital. Exceptions can be made in cases where the Pastoral Care Coordinator can invite other pastors to pray with particular patients if those patients request the services of their own pastor. However, when in hospital, most patients do not have the mental capability to make informed decisions and ask for the services of their pastor. Conversely, when the patients are discharged, the pastors, who are not involved in the hospital play a significant role in the decisions their patients make (Bopp et al, 2013:185).

Melissa Bopp, Meghan Baruth, Jane Peterson and Benjamin Webb confirm in their research the influence and importance of pastors in the lives of the people because pastors act as gate keepers (2013:185). They argue that “pastors are an important example of gateway providers because they have a very big influence over their flock and shape the physical and social settings for community health” (Bopp et al. 2013:185). In this case, pastors are key in guiding the decisions of discharged mental patients, as well as their guardians, regarding the patients' health. Harris Chilale and colleagues confirm this influence in the findings of a study they conducted in Mzuzu on the duration of untreated psychosis and associated factors in first episode psychosis (2014:504). Reporting on the health seeking behaviour of fourteen mental patients, they state that five patients consulted traditional healers, another five went to the hospital and that the remaining four depended on church prayers and counsellors (Chilale et al., 2014:504). This observation on health

seeking behaviour informs that when patients are discharged back to their communities after seeking hospital services, some of them and their relatives still consult pastors in search of faith healing prayers. A similar study carried out by Katherine Sorsdahl and colleagues (2010:S42), which examined the role of traditional healers in mental health seeking behaviour, showed that nine percent of the participants contacted traditional healers while eleven percent sought help from a religious or spiritual advisor [pastor]. These research studies clearly show that pastors cannot be overlooked when dealing with mental health care to patients. Indeed, local pastors are consulted by and asked to pray for many people – including patients and their relatives/guardians – who are recuperating from mental illness. Harold Koenig gives an example of a mentally sick person who may wish to take relief medicine but is counselled not to by the pastor or church members. Koenig (2004:1196) states that the pastor or the church member may “feel strongly that the patient should pray, read the Bible and lead a more wholesome Christian life, instead of taking medication”. This is also the case with patients in Mzuzu who go for faith healing prayers and are advised to stop prescribed medication. These patients, who are vulnerable, marginalised, sometimes perceived as less than human (Chan, 2010:2) and stigmatised (Cobb, 2005:58) because of their illness follow their pastors’ advice and consequently in some cases stop taking their medication. The discontinuing of treatment has led to many patients falling sick again and seeking readmission to Saint John of God Mental Hospital. If some mental patients commit suicide as a result of being mentally sick (American Psychiatric Association, 2013:149), then the frustration arising from the failed faith healing would result in higher suicide rates among these patients.

The cases of pastors’ advice to patients to stop medication, the subsequent re-admission and occasional death of patients have motivated me to critically evaluate the involvement of pastors in the delivery of care to people suffering or healing from mental illness. The researcher argues that the information and instructions from two divided fronts (the pastor and the doctor) suspends the marginalised mental patient between the doctor at the hospital and the pastor at his/her church. The doctor encourages the long term maintenance use of western medication (American Psychiatric Association, 2013:483, Xiang *et al.*, 2011:1325), while the pastor tells the patient that they will be healed through prayer (Brown, 2011:261). Given that the doctor is a member of the church and also follows the teachings of the pastor, the patient or guardian must wonder whose advice to follow. Throughout the researchers’ eight years’ worth of work experience at Saint John

of God Mental Hospital, he has also observed that it is mostly women who follow the advice of pastors regarding their illness. Apart from female patients following the advice of pastors, it is also women who have the burden of guardianship over patients during the time that they are in the hospital and once they are discharged back to their respective homes (Murray et al. 2017). Women have been generally described as “weak, vulnerable and easily influenced” (Tasca, 2012:110). This social constructed description seem to be similar to a situation of women reported by Joseph Osafo through his research conducted in Ghana (2016:496). Africa has been described as continent that has an overwhelming patriarchal influence in that men dominate women and children (Fox, 1969:31-21 cited in Rogers, 1975:727). Thus, while both male and female mental patients are oppressed and discriminated against because of their illness, the oppression and discrimination of women patients are more apparent (Mauleke and Nadar, 2002:6, Association of Women Rights in Development, 2004:1).

I have been engaged in counselling sessions with patients who have relapsed (falling sick again) because they followed the instructions of their pastor and stopped taking their medication after the pastor prayed for them. The relapse of patients has so many implications for the hospital, the medical practitioners, relatives and guardians and the community at large. Relapse increases the burden of care since patients require a long term treatment plan to get better. Anders Hakansson, Louise Bradvik, F. Schlyter and Mats Berglund argue that relapse “increases complications such as suicide attempts, alcoholism and violence” (2010:12). For the medical personnel and the counsellor, it is frustrating to work with the same clients again, especially when we have witnessed their healing and discharge from the hospital. While their healing offers me relief and joy, their relapse (even loss of life) because of conflicting information from the hospital and the pastors is disheartening. I argue that conducting this study will save the lives of patients and bring satisfaction and happiness to the hospital staff who act as secondary caregivers. The study will propose a good working collaboration between the hospital and pastors for the benefit of the patients. The findings of this research will help in proposing a multidisciplinary care approach that can mitigate the relapse of mental patients which is partly the result of the exclusion of pastors from the healing ministry. Furthermore, there is hope that this study will find ways in which to involve pastors in the care, health and healing of the mental patients at the hospital in order to contribute to sustainable healing and a drop in the relapse rate of patients in Mzuzu.

The researchers' position as a Pastoral Care Coordinator and my faith in Christianity serves both as a foundation for and background to this project. As such, biblical verses will be referred to where necessary to support some of the arguments in this study. Likewise, the personal experience acquired since 2011 as an employee of Saint John of God Hospitaller Services will be used to support some arguments.

1.2. A Brief Background to Mental Health in Malawi

Mental health issues in Malawi seem to have little importance short history despite it being vital to the wholeness of any person. World Health Organisation (WHO) defines mental health as “a complete state of wellbeing in which the individual realises his or her own abilities, can work productively and fruitfully and is able to contribute to his or her community” (WHO 2005). In contrast to such an image of well-being, Martin G. Wilkinson, a psychiatrist, Zomba Mental Hospital, in Malawi, states that:

The traditional picture of mental illness [in Malawi] is the very disturbed, possibly aggressive, half-naked man uprooting crops, burning houses, or walking down the white line on the road to Blantyre. Such a person would be regarded with fear and either be avoided at all costs, or strenuously restrained and handed over to the police. Yet there have always been other presentations of mental disorder – the silent, withdrawn individual, the child running off into the bush, the adolescent who almost unnoticed begins to lose concentration and fail at his studies. Most people will also recognise mental handicap and make allowances for those who cannot learn as quickly as their normal peers (1992:10).

The history of mental health healing in Malawi dates back to 1910 when disturbed prisoners were moved into a special wing of the prison, Zomba Lunatic Asylum (Maclachlan 1993:271; Wilkinson 1992:10). History has it that in 1943 “an annex provided improved conditions and ten years later, in 1953, Zomba mental Hospital [the only government mental hospital] was constructed” (Wilkinson 1992:10-11). According to Malcom Maclachlan (1993), the scarcity of institutionalised mental health services gave rise to the development of a district mental health service. The picture presented by Marc G. Wilkinson and Maclachlan improved when Saint John of God Hospitaller Services (where the researcher is working) started caring for people with mental health problems in the north and central region of Malawi in 1993 and 2013 respectively. This is

a significant improvement if compared to the situation that precedes it, a fact that the recent study that explored the barriers to utilization of mental health services in Malawi do not mention (Gonekani & Mselle 2017). Omero Gonekani Mwale and Lilian T. Mselle (2017) are among the few people who have written on mental health issues in Malawi. It is true that until recently, mental health services was among the least developed avenues in the country as stated by Chiwoza Bandawe (2010:15). Bandawe (2010:15) states that “the in availability of trained personnel and the hopelessness to the recovery of a mentally ill person makes the government not prioritise the treatment of mental illness”. However, the current situation is that apart from the three specialised (one owned by the government of Malawi and two owned by Saint John of God Hospitaller Services) facilities, today visiting mental health services are available at almost all district hospitals and non- governmental hospitals and also at the health centre level, though the latter is not fully developed (WHO, 2011:7). In this arrangement, a psychiatric nurse accompanies the district health officers in visiting the health centres in each district and critical cases are referred and managed by the three institutions specialised in mental health.

While 2005 WHO statistics indicated that the country had no psychiatrists (2005:31), since 2012, Malawi has gained two (2) Malawian psychiatrists, three (3) expatriate psychiatrists, 23 mental health clinical officers, 39 psychiatric nurses (MOH, 2012:11), a clinical psychologist and several social workers and occupational therapists working in mental health care. To supplement the numbers of health care workers, each year the government of Malawi trains 10 specialised psychiatric nurses as well as 10 psychiatric clinical officers that study psychiatry up to Bachelor’s degree level (MOH, 2012:21). All student nurses also have in their curricula a compulsory course on mental health and psychiatric nursing (MOH, 2012:13). This allows these nurses to get basic mental health and psychiatric knowledge and enables them to assist patients before an appropriate referral is made. In trying to contribute positively to the care and treatment of people living with mental illness, Saint John of God Hospitaller Services also opened its own college of health sciences in 2003 to train more psychiatric nurses, mental health clinical officers and psychosocial counsellors. Since its inception, this program has produced more than 100 nurses, 80 clinicians and 70 counsellors who are now working across the country. Additionally, the University of

Malawi, through its two constituent colleges (Kamuzu College of Nursing¹ and College of Medicine²), has started offering specialised undergraduate and postgraduate courses in mental health psychiatry to clinicians and nurses respectively.

In line with the above changes, the Malawi government launched its first mental health policy in 2001 with the view to ratify the Alma Ata Declaration for primary health care. The aim of the declaration was “to provide comprehensive and accessible mental health care to the citizens of Malawi, through the existing primary health care system” (Mwale and Mselle 2017:53). Mental health is now included in the Essential Package of Health Services (EPHS)³ which shows the determination of the government to prevent and treat mental illness (MHSSP 2011 – 2016). A drawback on this positive direction on mental health in Malawi is that, of the total budget allocated to ministry of health, mental health only has 1% assigned to it (WHO 2005; WHO 2002). Clearly, despite many improvements, mental health services remain inadequate in Malawi and are not regarded as a priority (Bandawe 2010:15).

1.3. A Brief Historical Background to Saint John of God Worldwide Mission

Saint John of God is a worldwide Catholic religious institution dedicated to the care of the poor, the sick and those suffering from mental disorders. The Order is named after Saint John of God⁴, commonly referred to in the Catholic Church as the patron saint of booksellers, hospitals, nurses, alcoholics, firefighters, the mentally ill and the dying. John Cuidad (who later became Saint John of God) was the only child born to his parents in Portugal in 1490. At the age of 8, he was taken “(either kidnapped or seduced by a cleric)” to Spain (Saint John of God, 2015:3). It is in Spain that he became a shepherd, a bookseller, a soldier and then later a health-care worker after experiencing

¹ <https://collegemw.com/admission-requirements-kamuzu-college-nursing/>.

² <https://www.medcol.mw/call-for-applications-mmed-in-psychiatry/>.

³ The Essential Package of Health Services is the package of services that the government of Malawi is providing to its citizens in an equitable manner.

⁴ The story was documented in the first biography of John of God by Francisco de Castro. Castro was a chaplain at John of God's hospital in Granada, Spain. He drew from his personal knowledge of John as a young man and also used material gathered from eyewitnesses and contemporaries of his subject. It is said that Castro began writing in 1579, twenty-nine years after John of God's death, but he did not live to see it published, for he died soon after completing the work. His mother, Catalina de Castro, had the book published in 1585 (*Hospitaller Order of Saint John of God West European Province (Ireland)*, 2015:4).

a change to his life at the preaching of John of Avilla. The instant conversation he underwent was perceived by the onlookers as a mental illness. As such he was taken to a mental hospital in Spain for treatment. After his experience in the hospital where he was treated and punished like a prisoner, and after his discharge, John started helping the poor and the sick. His biographer points out that John's everyday prayer was "may Jesus Christ eventually give me the grace to run a hospice where the abandoned poor and those suffering from mental disorders might have refuge and that I may be able to serve them as I wish" (Francisco, 1585:13). He died on 8th March 1550 on his 55th birthday (Eleanor, 2017:46). It is the followers of John who later formed what is today known as the Hospitaller Order of the Brothers of Saint John of God (O.H). The Hospitaller Order is currently found in 53 countries on all the continents (Saint John of God, 2015:4). Twelve of these countries are in Africa. The Order runs more than 390 centres serving people's medical health, mental health and psychiatric needs. The Family of Saint John of God, as those who commit to his vision are called, is made up of more than 45,000 brothers and co-workers (Saint John of God, 2015:6). They are supported by many benefactors and volunteers who identify with and support the work of the Order.

1.4. Saint John of God Mission in Malawi

The Saint John of God services in Malawi are directly linked to Ireland, which is the centre of the West European Province. The brothers started their mission in Mzuzu, Malawi in October 1993 in response to an invitation by Monsignor John Roche who was the apostolic administrator of the diocese of Mzuzu (*Saint John of God Hospitall Services Malawi Ltd (2014-2017 Strategic plan)*, 2013:2). Roche invited the brothers to establish a community based mental health service as part of the church's response to the growing health care needs of the people of the northern region of Malawi. As pointed out earlier on, the Hospitaller Brothers of Saint John of God are best known for caring for the sick and the poor. It is for this reason that they always respond to the health care needs of a particular region. The initial service development in Malawi was done in conjunction with the Primary Health Care (PHC) department of Saint John's Mission Hospital, a constituent health facility of the Diocese of Mzuzu. From such a small beginning, Saint John of God Community Services has grown to the present day multifaceted approach to the development of people in the context of the challenges they face at each stage of their life span (*Policies and*

Standards of Saint John of God Hospitaller Services in Malawi, 2011:2). Apart from offering mental health services, the Hospitaller Order operates a college of health sciences, services for the elderly, addiction and recovery services, the Institute for Vocational Training (IVT), the Child Development Centre (CDC) and cares for street children in Mzuzu. As part of income generating activities for self-sustenance, the centre has a business enterprise in screen printing and it offers cafeteria and conference rooms as well as landscaping services. In October 2013, the centre extended its services to the central region (Lilongwe) where mental health services are offered (*Saint John of God Hospitall Services Malawi Ltd (2014-2017 Strategic plan)*, 2013:2).

1.5. Research Problem

This study critically evaluates the involvement of pastors of other denominations with mental patients at Saint John of God Mental Hospital in Mzuzu, northern Malawi, with a view to enhance sustainable quality care of mental patients when they are in the hospital and discharged to their community. The exclusion of pastors from the healing ministry has negative implication on patients and their guardians. As a result of their initial exclusion, these pastors are consulted by mental patients or their family members once they are discharged from the hospital. Most of these religious consultations usually lead to conflicting advice. In some cases, the pastors advise the patients to terminate medication and trust in the faith healing prayers they offer. The piece of advice can contribute to the relapse and even death of patients. This research project critically evaluates how to responsibly involve pastors in the caring of mental patients while they are undergoing treatment. Based on the discussion, the problem that this research project wants to conduct is an evaluation of the involvement of pastors in the healing ministry to mental patients and how this contribute to the relapse and even death of patients at Saint John of God Mental Hospital in the northern region of Malawi.

1.6. Research Question

How could pastors of other denominations be involved in the care and mental health healing at Saint John of God Mental Hospital in order to offer a successful and sustainable healing ministry to patients?

1.7. Hypothesis

Pastors from other denominations should be involved in the healing ministry offered to mental patients at Saint John of God Mental Hospital in Mzuzu.

1.8. Goals and Objectives of the Study

The study aims to critically evaluate the exclusion of pastors of other denominations in the treatment of people with mental illness at Saint John of God Mental Hospital. To achieve this aim, this study has the following objectives:

- i. To determine the extent of the impact of the exclusion of pastors in the delivery of mental health care at Saint John of God
- ii. To explore the contributions these pastors make to health care delivery
- iii. To determine the feasibility of including pastors of other denominations in the sustainable healing of patients at Saint John of God Mental hospital

1.9. Methodology

This study is based on the evaluation of the policy document of Saint John of God Mental Hospital in Mzuzu. Saint John of God hospital has a policy document to guide the operations of its services in all of its 12 departments: Administration, Saint John of God Centre, House of Hospitality (HOH), Institute for Vocational Training (IVT), Child Development Centre (CDC), Pastoral Care, Counselling, Saint John of God College of Health Sciences (SJOGCOHS), House Keeping and Catering, Maintenance and Horticulture. The focus of this evaluation will be on pastoral care policies that restrict pastors of other denominations from conducting prayers at the hospital. Apart from the policy document, the study will analyse secondary data (texts and articles related to mental health healing practice) which discuss the inclusion/exclusion of pastors in mental health care practice. This research is non-experimental, hence the choice of a case study. The study uses Saint John of God Mental Hospital as a case study and employs literary qualitative research

methodology. The methodology is appropriate because the study will be conducted through textual analysis.

1.9.1. Practical Theology Approach

Practical theology as a branch of theology follows a unique approach to engage and analyse different human experiences within an empirical setting. It is theologically sound and relevant to the given context. In this research project, I use the practical theology approach by employing the four tasks of practical theology as propagated by Richard Osmer (2008:4). The four tasks are: the descriptive-empirical (what is going on?), the interpretative (why is it going on?), the normative (what ought to be going on?) and the pragmatic task (how might we respond?). Osmer argues that these four tasks guide the interpretation of and responses to a situation. In the case of this study, it is the involvement of pastors in the care of patients grappling with mental illness. This section discusses the four tasks of practical theology that Osmer (2008) advises congregational leaders and academics in the seminary to use. The goal of these tasks, according to Osmer, is to teach congregational leaders a way of approaching situations with skills and knowledge. Osmer further points out that good ministry is not a matter of solving problems; but rather offering support and exploration of those problems (2008:x). Osmer's (2008:11-12) primary purpose in his approach is to equip congregational leaders to effectively engage in the practical theological interpretation of episodes, situations and contexts that confront them in their ministry. A secondary purpose is to equip theological students, those engaged in Master of Divinity and Doctor of Ministry programs, with the skills of practical theological reflection (Osmer, 2008:x). It is with this purpose that Osmer proposes a methodology of practical theological interpretation consisting of four tasks. Below, the study briefly present the four tasks as proposed by Osmer.

1.9.1.1. The Descriptive-Empirical Task

This task asks the question: What is going on? It is presented through the biblical image of priestly listening. This task is concerned with the gathering of information which is used to discern the designs and dynamics of particular episodes, situations and contexts. Apart from gathering information, Osmer argues that "it has to do with the quality of attentiveness congregational leaders give to people and events in their everyday lives" (2008:33). In this case, the

congregational leaders have to possess a spirituality of presence in that they are able to attend to people in the presence of God, be it in informal, semi-formal or formal contexts. Informal attending involves listening and showing genuine concern to the suffering of the people. Semi-formal attending has to do with arrangements like small groups where people gather and get support regarding their predicament. Finally, formal attending interrogates, studies and researches episodes, situations and contexts. Osmer (2008:12) defines the above three terms or “categories” as he calls them in the following way: An episode is an incident or an event that emerges from situations in daily life and causes explicit attention and reflection. In this case, it is a single setting and happens over a short period. A situation is a broader and longer pattern of events, relationships and circumstances in which an episode occurs. It is generally viewed as a narrative within which a particular incident is located as part of a longer story. A context consists of the social and natural systems within which a situation unfolds.

The descriptive empirical task, as outlined above, has been used in this chapter (Chapter One) to foreground the research agenda regarding what is going on at Saint John of God Mental Hospital, necessitating this project. In fact, it is the exclusion of pastors of other denominations from the ministry of mental health healing that inspired this evaluative research project. Further, the first part of Chapter Two also uses the descriptive-empirical task, not in the sense of the systematic gathering of data through field research, but in the presentation of relevant existing secondary empirical resources such as the policy documents of Saint John of God Hospitaller Services.

1.9.1.2. The Interpretive Task

The second task responds to the question: Why is this situation going on? Osmer states that at this stage, the researcher or the congregational leader needs to step back in order to make meaning of what they have discovered (Osmer, 2008:17). This task is biblically represented by the image of sagely wisdom, referring to Old Testament wisdom literature and Jesus Christ as the epitome of wisdom in the New Testament. More inquiries may be made at this time to ascertain why the incident took place. By using different theories from other disciplines like arts and science, the researcher will understand the occurrence of certain patterns and dynamics. Osmer further argues that “being contextual, practical theological interpretation thinks in terms of interconnections,

relationships and systems”(2008:17). For ordinary people in everyday life, the interpretive task is achieved through the art of hermeneutics, which is the science of interpretation. This is the reason why pastoral caregivers must build rapport with people through listening to them. Naturally, human beings like interpreting their environs and life experiences to make sense of the things happening to and around them. In academics, the interpretive task enables the researcher to engage with available data, have new insights to test theories and come up with novel ideas (Osmer, 2008:17). The second part of Chapter Two employs the interpretive task to make sense of the policy that excludes pastors of other denominations from the healing ministry to mental patients.

1.9.1.3. The Normative Task

The question that normative task asks is: What ought to be going on? The normative task applies theological concepts in order to interpret particular episodes, context and situations in the community or congregation (Osmer, 2008:4). Such interrogation is aimed at finding ethical principles, guidelines and rules that would speak to the human beings affected by the situation at hand in order to come up with plausible plans and strategies. It helps individuals to construct norms which guide their responses and strengthen the learning of good and acceptable practices. In dealing with the dimension of interpretation, the normative task relies on knowledge from other disciplines like social sciences and theology in order to ask questions regarding episodes, situations and contexts. Osmer (2008:8) states that “these questions lie at the heart of the normative task of practical theological interpretation.” The biblical image that the normative task has is that of prophetic discernment. In this study, Chapter Three and Chapter Four engages the normative task in order to focus on the inclusion of pastors in the ministry to patients with mental illness and the contributions they make. As pastors are excluded from the delivery of mental health care and patients continue to access the services of these non-Catholic pastors, additional questions relating to such behaviour need to be asked. These questions include: What ought to be going on? What are we, as a community of Christians, to do in response to these events? How might God be acting in this situation or context? What patterns can human beings use to respond to these situations? Chapter Three also employs the normative task with its three norms, namely theological, ethical and good practice, in order to analyse published research related to the contributions made by pastors to health care delivery in other hospitals. This analysis is done in order to respond to the

normative question: What ought to be going on? Likewise, Chapter Four also responds to this question by suggesting ways of involving and including pastors in the healing ministry of mental patients at Saint John of God Mental Hospital.

1.9.1.4. The Pragmatic Task

The Pragmatic task deals with the question: How might we respond? Osmer (2008:4) states that the pragmatic task “determines strategies for action that end up influencing situations positively and enter into reflective conversation coming from the responses of enacted activities.” It is under this task that leaders’ critical abilities are involved. Three forms of leadership are stated, namely: “task competence, transactional leadership and transforming leadership” (Osmer, 2008:176-178). Task performance concerns the leader’s ability to perform their role in an organisation well. Transactional leadership entails the ability to influence other people to perform certain actions and play certain roles through a process of rewards trade-offs. Transforming leadership involves renewing the organisation through deep change in its identity, mission, culture and operations. Put together, these three types of leadership present the spirituality of servant leadership as the biblical image of the pragmatic task. This task empowers people to grow and experience spirituality according to the life and teachings of Jesus Christ. Both Saint John of God Mental Hospital and the excluded pastors are called to a spirituality of servanthood for the benefit of patients struggling with mental illness. When the hospital’s authority competes with the pastor’s authority, it is the innocent and vulnerable mental patient that suffers the consequences through multiple re-admissions or, in extreme cases, death. Saint John of God should realise that:

[T]he Lord is a servant and the servant is the Lord. Power and authority are defined. A reversal takes place. Power as dominion, or as power over, becomes power as mutual care and self-giving. Power as seeking one’s own advantage becomes power as seeking the good of others and the common good of the community (Osmer, 2008:191).

I use the pragmatic task in Chapter Four to propose ways of collaboration between medical personnel and the excluded pastors. Chapter Five also employs the pragmatic task in order to come up with suggestions and recommendations for further actions. It uses the pragmatic task as it reiterates the main themes discussed in the thesis, evaluates the research question, hypothesis and the objectives and finally, presents possible suggestions and recommendations for further

consideration. This is done in view of answering the pragmatic task question: How might we respond to the exclusion of non-Catholic pastors from Saint John of God Mental Hospital?

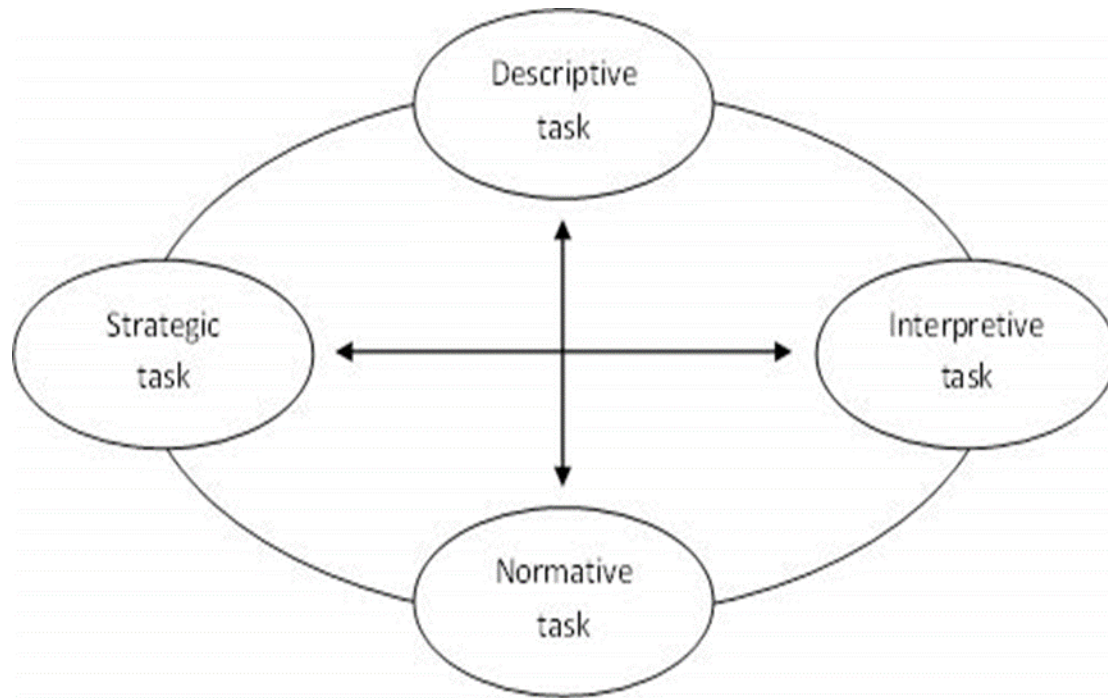


Figure 1:1 The Adapted diagram from Osmer (2008:11), summarising the four tasks

Figure 1:1 summarises the four tasks of practical theology as provided by Osmer and forms a basic framework for this study. Osmer (2011:2, 2008:4) states that these tasks “have commonly been represented for many years in the writings of various practical theologian, as well as within the Clinical Pastoral Education (CPE) and Doctor of Ministry programmes and field education seminars”. As methodology in practical theology, these tasks are enough to respond to the question of this research, however, they work in spiral rather than a circle as they constantly fall back and forth to other tasks that have already been explored. To respond to what is going on, the research foregrounds the area that needs special attention in the background to this study. With regard to the second task, the study suggests reasons as to why pastors are excluded in the delivery of mental health care at Saint John of God Mental Hospital. The last two questions (What ought to be going? And how might we respond?) are used to propose ways to find possible solutions to the problem and provide recommendations for practice. It is noteworthy that Paul Ballard and John Pritchard (2006:16) also suggest four similar tasks as practical theological methodology. The major

difference is in the terms they terms use. Ballard and Pritchard call the four categories as: the descriptive, normative, critical and apologetic task. This shows that Osmer's tasks are not completely new, but that the hermeneutical methodology that he proposes adds novelty to the existing tasks.

1.10. Ethical Consideration

The researcher is aware of the ethical component when conducting research. However, this study uses secondary documents which are in the public sphere (Saint John of God policy booklet, Books in the Library and peer reviewed articles). As such, the author exercised due caution in analysing the aforementioned texts (Strydom, 1998:34). All sources consulted and used, either through quotation or paraphrasing, have been clearly referenced.

1.11. Limitations

The study is limited in its scope. It is a case study focusing on Saint John of God Mental Hospital in Mzuzu which is in the northern part of Malawi. The geographical location aside, the second limitation is that the researcher is an employee of the same hospital and a member of the Catholic Church. On the one hand, research from inside of an institution is problematic as it becomes difficult for one to carry out an objective analysis of the entire situation (Fouche and De Vos, 1998:125). On the other hand, this same limitation acts as a positive qualifier. As an insider the researcher has knowledge, technical know-how and experience that may not be available to someone who is doing the research from a neutral or external position. His experience as an insider for eight years and working in the Pastoral Care Department where this research is focusing its evaluation, gives me enough experience to carry out this study. The last limitation of this study concerns the method used for data analysis. As indicated in the methodology section, the study has employed document analysis. Adilia Silva (2012:141) states that "each and every document has a specific social context and identity" leading the researcher to have a selective and biased understanding of the document. Further, authors of different texts "record and leave out information in accordance with their own assumptions" (Silva, 2012:141). However, these limitations will be overcome by an analysis of the policy document(s) of Saint John of God Mental Hospital in conjunction with other published texts and peer reviewed articles related to inclusion

of pastors in the delivery of mental health care to the ministry of mental patients. In doing this kind of comprehensive analysis, the researcher has minimized the degree of subjectivity in the findings. Since the research is done through document analysis, there is no contact with any human subject in the course of analysing data for this study. Owing to the limitations discussed here, it is not possible to generalize the findings and recommendations of this research.

1.12. Significance of the study

This topic of study is very important because my work as a Pastoral Care Coordinator “involves accessing religious leaders of different denominations as demanded by the patients in pursuit of providing pastoral care”⁵. The evaluation the policies that exclude pastors in the delivery of mental healthcare will assist not only the patients to access holistic care but also the health care workers who will not labour to work with the same patients over and over again. The outcome of this research will assist my own career progress, that of the pastoral Care Coordinator Office at the Saint John of God Mental Hospital, and also that of other pastoral care workers in a clinical setting. This will also reduce the frustration experienced by the different people (relatives, guardians, hospital workers and patients themselves) affected by patients’ relapse. Further, in an effort to respond to the emerging mental health demands in Malawi, Saint John of God Hospitaller Services has opened another centre in the capital city (about 400 km away from the existing facility which is the setting for this study). Although there is some progress, the country seems to be where America was in 1841 when Dorothea Lynn Dix visited a house of correction in Massachusetts and found mentally ill people chained to the walls (Clinebell 1970:11). In Malawi today, “some people with mental illness are still restricted in their movements by being tied to a tree, a big stone or being locked up in the house” (Breugel, 2001: 85). JVM van Breugel (mis)interprets such treatment as a form of respect (2001:85). An evaluation of the policy document which may result in inclusive caregiving options will enhance care of the people with mental illness. In the same vein, the analysis will enhance sustainable healing to patients suffering and recuperating from mental illness. Inclusive care to mental patients can be seen as another form of progress.

⁵ These are documented in the job description of the Pastoral care Coordinator.

1.13. Theoretical Framework

This study evaluates the exclusion of pastors from other denominations from the healing ministry of mental patients at Saint John of God Mental Hospital in Mzuzu. As such, it is located in the field of pastoral care and counselling. The aspect of health healing that this thesis focuses on is a western biomedical healing which is done in Mzuzu, Malawi, an African country. For this reason, the study discusses the African world view to understand the cultural environment in which Saint John of God Mental Hospital is operating. In agreement with Loraine Mackenzie Shepherd, an ordained systematic and feminist theologian, who opposes the view that interdisciplinary studies are difficult to do and are more superficial (2002:6), the researcher believes that the interdisciplinary nature of this study makes it relevant in today's world. The research paper is informed by feminist theology (to advocate a voice for the voiceless mental patients), the African synod and inculturation and African understanding of sickness and healing as a benchmark for evaluation of the policy document on exclusion of pastors.

1.13.1.Feminist Theology

The purpose of this study is not to discuss the vast body of liberating theology that is concerned with the oppression of women and underprivileged people. However, a general discussion of feminist theology will be of help to this study in evaluating policies related to the care of mental patients who need liberation from their marginalised conditions. While Rakoczy IHM (2013:11) states that feminism is critical and constructive, Natalie Watson (2004:2) argues that feminist theology is also contextual and creative. Furthermore, Rakoczy argues that feminism “is based on the conviction of the full humanity of women and is engaged in reconstructing human society, including religious institutions, to reflect women's equality with men” (2013:11). As a working definition, Watson proposes the following:

Feminist theology is the critical, contextual, constructive and creative re-reading and re-writing of Christian theology. It regards women – and their bodies, perspectives and experiences – as relevant to the agenda of Christian theologians and advocates them as subjects of theological discourses and as full citizens of the church (2004:2-3).

Anne Clifford (2001:18) argues that a patriarchal society or culture “is initiated by men in positions of power, continues to be maintained primarily by men and has men as its principal beneficiaries.” Patriarchy then strikes at the “core of women’s humanity and it is an ideology, a way of thinking, feeling and organizing human life which legally, politically, socially and religiously enforces male dominance and power” (Rakoczy IHM, 2013:10). Patriarchal systems of governance are present in culture, society and religious bodies across the globe. Consequently, Watson’s disclaimer is of particular interest to this study. She states that:

[F]eminist theology does not seek to be one more voice represented at the table of patriarchy, neither does it advocate for the complete separation of women from men, but feminists theologians aim at the transformation of theological concepts, methods, language and imagery into a more holistic theology a means and expression of the struggle for liberation (Watson, 2004:3).

In a slightly different approach, Loraine Mackenzie Shepherd uses the term feminist to describe an approach that is attentive to multiplicative⁶ sources of domination within church and society, only one of which concerns gender (2002:3). To Shepherd, “feminist” implies a liberating approach that sets as its criteria the liberation of the oppressed and the respect of diversity. As a member of the family of liberation theologies (Rakoczy IHM, 2013:23) like that of Latin America developed by the Peruvian priest, father Gustavo Gutierrez (1988), feminism appears on the scene as a real revolution both in theory and practice. The feminists uprising encompasses all dimensions of human existences, including sociological, political, economic, cultural and religious spheres. If feminist theology is practiced in Christian circles, it becomes “part of the worldwide movement of women of faith to engage in radical critique of Christian life” (Rakoczy IHM, 2013:4). Christian feminists want to see if patriarchal Christian foundations can support a new wave of thinking, speaking and acting which affirms that all human beings are created in the image of God. It is in such realms that feminist theology challenges the past and present theology and praxis, challenging presuppositions, beliefs, dogmas and the entire Christian life from women’s point of view (Rakoczy IHM, 2013:4)..

⁶ As used by Elizabeth Schussler Fiorenza, the term describes the effects of multiple oppression experienced by one person. The impact is not merely multiplied by the number of oppressions (double or tripled), but exponentially multiplied (one oppression multiplied by another, multiplied by another).

Rakoczy states of interlocking oppressions like sexism, economic injustice, racism, sexual orientation, social standing and the exploitation of non-human nature – making the feminist agenda inclusive of all the human concerns (2013:14-15). Because mental patients are often discriminated, oppressed and rejected at different levels and mental illness is often seen as a gendered disease, two aspects of liberation theology are relevant to this study: the preference that is given to people who are poor and living on the margins of society (Rakoczy IHM, 2013:9). Sandra M. Schneiders points out that “it is a right of all human beings not withstanding their health status to be given full participation in society and culture in order to recreate humanity according to patterns of eco-justice” (2000:8).

1.13.2. The African Synod and Inculturation

As stated in the historical background above, Saint John of God Mental Hospital is owned by the Catholic Missionary brothers of Saint John of God. Around the same time that the hospital started its mission in Malawi in 1994, there was a meeting in Rome for all African bishops. This African Synod was a special assembly of the African bishops called by the Pope to explore the overall situation of “Christians in Africa in order to encourage an ever more effective and credible witness to Christ in every local Church, every nation, every region and on the entire African Continent” (Pope John Paul, 1995:para 127). At the end of this meeting, with the approval of late Saint John Paul II, the bishops produced a document entitled *Ecclesia in Africa*. The aim of the meeting and the subsequent publication of the document was to make Africa and Africans at home with the Gospel message of Christ, taking into consideration their specific cultural heritage, cosmology and their epistemology. It is on this document that I will focus in this section, in order to consider its major points of discussion and recommendations. Based on this discussion, I will then evaluate the Saint John of God Mental Hospital’s policy and whether or not it is in line with the post synodic exhortations. It is worth noting that the second Vatican Council (1962-1965), which launched a real transformation in the Catholic life and practices of faith, had its own recommendations regarding the Catholic Church’s association with other faith groups. It stated that the Roman Catholic Church after all:

rejects nothing of what is true and holy in these religions, she has high regards for the manner of life and conduct, the precepts and doctrines which although differing in many ways from her own teaching nevertheless often reflect a ray of truth which enlightens all men. Indeed, she proclaims, and ever must proclaim Christ "the way, the truth, and the life" (John 14:6), in whom men may find the fullness of religious life, in whom God has reconciled all things to himself (Flannery, 1980:739).

It is clear from this Vatican Council II standpoint that the Roman Catholic Church should not labour alone to create an improved society for people. In the same spirit of inclusiveness, Douglas Waruta and Hannah Kinoti commend that "we have to forge ahead together – Christians, Muslims, African traditionalists and any others – to build a peaceful humane, materially and spiritually prosperous society" (2000:22-23).

Ecclesia in Africa (1995) is a direct outcome of the African synod of bishops in Rome produced by Pope John Paul II. *Ecclesia in Africa* has seven chapters but for the sake of this study, I will limit myself to two chapters: "The church in Africa" and "Evangelisation and inculturation". These chapters specifically focus on making the gospel message flesh among the people in Africa. Agreement on the importance of inculturation was a major outcome of the meeting and the term is defined as "a movement towards full evangelisation which seeks to dispose people to receive Jesus Christ in an integral manner. It touches them on the personal, cultural, economic and political levels so that they can live a holy life in total union with God the Father, through the action of the Holy Spirit" (Pope John Paul, 1995:62). Similarly, Phillip Knights defines inculturation as "an intimate transformation of the authentic cultural values by their integration into Christianity and the implantation of Christianity into different human cultures" (1994:1). In *Cura Vitae*, Daniel Louw, a renowned academician in the field of pastoral care, describes inculturation as "the gospel being enfleshed and embodied within the paradigm of a specific local culture, without losing the awareness of multicultural pluralism, i.e. the reality of different cultures (identities) within a system of dynamic interaction and inter-dialogue" (Louw, 2008:151). Moving away from the definition of the word itself, Elen Verstra and colleagues point out that "inculturation takes place when the gospel and the church no longer seem to be foreign imports but are claimed in general as the property of the people" (cited in Dube, Shoko and Tabona, 2011:79). In other words, Charles Nyamiti argues that inculturation can only take place once the Bible and the church tradition are

directly confronted by African traditional wisdom, problems and aspirations up to the point that one has to ask, what has Christianity to do with African traditional values?" (Cited in Dube, Lilian, Shoko and Tabona, 2011:79).

Inculturation, based on the discussion above, is therefore a process through which faith enters the life of individual people and their immediate communities. Inculturation is an instrument through which a community opens itself to the richness of Christian holiness only if that community is able to integrate the positive values of a specific culture with the values of the Gospel. While confirming the need for inculturation, David Bosch (1991:385) brings in the concept of contextualization in order to liberate the inhabitants. For Bosch, "the Christian faith has never existed except as translated into a culture and it is not a surprise that in the Pauline churches, Jews, Greeks, Barbarians, Thracians, Egyptians and Romans felt at home because they expressed the faith in their own culture" (1991:388). Unfortunately, against such a background, Christianity was regarded as western culture upon its arrival in Africa.

The bishops at the synod affirmed that there should be "a serious concern for a true and balanced inculturation in order to avoid cultural confusion and alienation in our fast evolving society" (Pope John Paul, 1995:para 48). It is in the same paragraph that the Pope makes a specific reference to his historic visit to Malawi in 1989 by saying that "during my visit to Malawi, I challenged Malawians to reject a way of living which does not correspond to the best of their traditions and Christian faith" (Pope John Paul, 1995:para 48). John Paul II encouraged Malawians in particular and Africans in general "not to look outside Africa for any riches but inside their own traditions which can offer them genuine freedom and Christ who can lead them to the truth." In reference to Acts 1:8 that says "you shall be my witnesses", the synod urged Africans to be witnesses in all aspects of their lives since Africa has now become a new homeland for Christ and his message.

The synod fathers recommend that all Africans be missionaries to fellow Africans and the people of the world who have not yet received the message of salvation. It is from this angle that I see a shift in evangelisation. While Western missionaries brought the gospel from Europe to Africa, the gospel message must now first be carried to Africans within Africa before going beyond the borders of the African continent. Taking into the context that Africa has been a continent ravaged by outbreaks of violence, wars, hatred and conflicts, the synod fathers encourage Africans "to

preach the message of hope and resurrection bearing in mind that Africa is not dead but it is destined for life” (Pope John Paul, 1995:para 57).

The topic of inculturation was high on the agenda during the African synod meeting. Paragraph 59 of the Post Synodal exhortations states that on several occasions,

[t]he Synod Fathers stressed the particular importance for evangelisation of inculturation, the process by which catechesis takes flesh in the various cultures. Inculturation includes two dimensions: on the one hand, the intimate transformation of authentic cultural values through their integration in Christianity and, on the other, the insertion of Christianity in the various human cultures. The Synod considers inculturation as an urgent priority in the life of the particular Churches, for a firm rooting of the Gospel in Africa. Inculturation is a requirement for evangelisation, a path towards full evangelisation and one of the greatest challenges for the Church on the Continent on the eve of the Third Millennium (Pope John Paul, 1995:para 59).

Theologically, inculturation is linked to and understood better in union with the mystery of incarnation. Through incarnation, Jesus, the Son of God took human form in place and space. Jesus lived among people who had their own culture, a people who were chosen by the God who remained with them throughout the salvation human history. Just as the word of God became flesh and pitched his tent among us (John 1:14), so too the Gospel must be proclaimed to the nations by taking seriously the life situation of the recipients. Inculturation allows the Gospel to be inserted into people’s cultures. The fact that Jesus Christ humbled himself and lived among people (Phil. 2:6-9), provides a standpoint on the encounter of cultures with the same Christ and his Gospel. These Gospel values will in the end transform culture. Just as Jesus, the son of God became like a human being in everything except sin, “the inculturation of the Gospel message takes on all authentic human values, purifying them of sin and restoring to them their full meaning” (Pope John Paul, 1995:para 60).

Finally, the synod fathers admitted that inculturation is not an easy task to be accomplished. For them and indeed for everyone involved, inculturation is “a difficult and delicate task because it raises the question of church’s fidelity to the Gospel and the apostolic tradition amidst the constant evolution of cultures of the world” (Pope John Paul, 1995:para 62). Since culture is not static, it is

constantly transforming through interplay, resulting in dynamism, adaptability, reformulation and change, communities of faith must respond to this ongoing movement through constant inculturation. The other challenge posed by inculturation on the African continent lies in ensuring that all Christians will fully integrate the word of God as they remain faithful to African cultural values. With the help of the Holy Spirit who guides the church to the truth (John 16:13), the challenges of inculturation of faith in every area of Christian and human life becomes an achievable task.

The whole essence of inculturation lies in the realisation that Christ, the redeemer of the human race, is above any culture and operates through culture to transform it. Yet when the missionaries came to Africa with the gospel, “they viewed African culture from a colonial Christian perspective and declared it intrinsically wrong” (Louw, 2008:152). Louw further states that “within the African continent, any person who is African cannot be understood separate from cultural issues and values as human beings are embedded in culture” (Louw, 2008:153). With such an understanding, it is difficult to comprehend religion, faith, healing and spirituality in Africa without a proper understanding of its culture.

1.13.3. Understanding of Illness and Healing in Africa

Colonisation and missionary work reproduced various marginalities in Africa. Missionaries found a fertile ground to preach the gospel to people thought to be primitive and backwards in thinking. Louw affirms that “it is in Africa that slavery and racism was systematically practiced” (2008:148). Despite all these negative influences from outside the boundaries of Africa, most people in African communities have their understanding of illness and healing which is in most cases different from Europe (Louw, 2008:147). Indeed, the worldview that the African people have determines their understanding of health and disease as well as their approach to illness and its causes, diagnosing illness and the healing criteria for different illnesses. Though Louw (2008:23) acknowledges the impossibility of separating health and sickness or illness and healing, the discussion here is done under two specific titles for the sake of order and clarity: African understanding of illness and African understanding of healing.

1.13.3.1. An African Understanding of Illness

Most people in African communities view and perceive the world as a whole. This view determines their understanding of illness and healing. In Africa, illness always has a cause. Vhumani Magezi argues that “if someone is ill, it is assumed that there is an active intervention of a certain agent who may be human (a sorcerer or a witch) or non-human (a ghost, an ancestor, an evil spirit), or mystical (a deity or other very powerful being)” (2006:510). Likewise, for Philomena Mwaura illness in Africa is “often attributed to breaking of taboos, offending God and/or ancestral spirits; witchcraft, sorcery, evil eye, passion by an evil spirit and a curse from parents or from an offended neighbour” (2000:79). The ill person is therefore seen “as a victim, the object of aggression or as serving a penalty directed specifically at him or her because of a certain misdemeanour” (Berinyuu 1988:49-50 cited in Louw 2008:169). Thus, supernatural causes are mostly perceived as the causes of illness in Africa, while in the West, illness is attributed to non-supernatural causes. As such, the way the west approaches treatment differs from how it can be done in Africa. Although sickness and illness work as exchangeable and variable terms in day to day usage, Louw, on one hand, defines sickness as “the biological and physiological dimension of medical pathology and the total predicament of being a patient or being hospitalised” (2008:105). On the other hand, he states that the general definition of illness could be a:

disturbance or disharmony in the optimal psychosomatic functioning of the body system and the human person including the possibility of an existential disorientation which affects the social and psycho-religious functions of the total person. Illness could also be described as an obstacle resulting from the lack of effective functional meaning systems and future oriented values. Illness is closely related to sick behaviour and dysfunctional reactions (Louw, 2008:107-108).

The definition of illness above shows that the entire person is affected by illness in different dimensions. As such, healing will be successful only when all the affected dimensions are addressed. Africans, as any other people of the world, perceive illness as one of those unwelcome tragedies and misfortunes which affect the physical dimensions of human existence. While illness and misfortune are said to have spiritual causes and therefore, can only be healed through spiritual intervention, it is a physical reality and they cannot deny its presence (Dube, Shoko and Tabona, 2011:41). In Africa, “hunger, poverty, unemployment and violence, misuse of power and authority

are also causative agents of sickness” (Louw, 2008:146). Akyeampong, Hill and Kleinman (2015:252) agree that many African communities “believe that some conditions have cultural and traditional rather than medical causes and therefore they cannot be responsive to western medicine”. Most Africans therefore seek the services of a traditional healer who can make a proper diagnosis of the illness at hand. Though most Africans are aware, through a western education system, that “some illnesses have natural or organic causes, there is still an overriding belief in the supernatural or spiritual cause of any illness” (Waruta, Douglas and Kinoti, 2000:79). Agreeing with this belief, Dube, Shoko and Tabona (2011:183) point out that “even though people know that Malaria is transmitted by the bite of an infected mosquitoes, they still ask: ‘what made that particular mosquito bite me rather than someone else?’” The end result of such questioning is that the actual bite will be attributed to witchcraft or another human cause. In his book, *Pastoral Care to the Sick in Africa*, Abraham Adu Berinyuu (1988:5) states that for the African, life is an integral whole of cosmic and social events:

In Africa, there is no division and/or differentiation between the animate and inanimate, between the spirit and the matter, between living and non-living, dead and living, physical and metaphysical, secular and sacred, the body and the spirit, etc. Most Africans generally believe that everything (human beings included) is in constant relationship with one another and with the invisible world and that people are in a state of complete dependence upon those invisible powers and beings. Hence, Africans are convinced that in the activities of life, harmony, balance or tranquillity must constantly be sought and maintained. Society is not segmented into, for example, medicine, sociology, law, politics and religion. Life is a liturgy of celebration for the victories and/or sacrifices of other people.

As is apparent from the above discussion, illness in Africa is connected to suspicion, leading to a deeper search for underlying factors. In this case, illness is seen as a result of the active and purposeful intervention of an agent, who may be human, ghost, or supernatural (Louw, 2008:169). In dealing with illness then, this supernatural factor implies that before any healing can take place, contact with the spiritual world must first be revised and restored. In this sense, Louw has a four point summary regarding illness on the African context that proves useful. Firstly, he says that illness is not necessarily connected to bacteria, viruses or infection; secondly, illness implies that the harmony of societal order has been disturbed; thirdly, illness and health have a communal

dimension; and lastly, illness as a cosmic event that befalls one cannot be separated from the reality of death (2008:170).

If we shift focus to specifically mental illness in Malawi, many of the patients display the following signs and symptoms: violent or aggressive behaviour, disturbed behaviour, sleep disturbance, suicide attempts, depression, anxiety, alcohol and drug dependence and interpersonal problems (Kauye et al. 2015:125). The International Classification of Disease – 10th Revision (ICD-10) guides clinical officers in their profession and allows them to

link these symptoms to different types of mental illnesses, like dementia, schizophrenia, psychotic disorder, mania, bipolar affective disorder, depression, anxiety disorder, nonorganic sleep disorder, puerperal mental disorder and mental retardation (Kauye et al. 2015:126).

In the case of research done among the Tumbukas in Mzuzu, it becomes clear that people make no distinction between schizophrenia and other types of mental illness. As observed by Anthony Sefasi, et al (2008:161), “mental or behavioural problems that are recent in onset and considered to be medical or treatable are called *kuzweta mutu*, which translates as ‘confusion of the head’”. People who display such problems are called *wakufuntha*, a word that portrays no hope of recovery. It is therefore not surprising that people fear and avoid mentally ill people, restrain them and hand them over to the police.

1.13.3.2. African Rituals of Healing

Toyin Falola and Matthew Heaton (2006:1) contend that “even the most cursory examination of the academic literature of African studies shows that scholars tend to suggest that there are two ways of doing things in Africa: the traditional and the modern” (cited in Bosch-Heij 2012:25). As such, it is important to note that Africa is a continent that believes in extended (community) families and consequently operates in very particular way. To exist in Africa is to co-exist, as is stated by John Mbiti’s popular quote, “I am because we are, because we are, therefore I am” (1970:141). A similar proverb exists in Malawi: *Mwana wa mnzako ngwako yemwe, ukachenjera manja udyana naye* (your neighbour's child is your own child, his/her success is your success too). It is from such a background that sickness is seen to be communitarian in nature (Somé 1999:22). The healing of the individual, in this case, is consequently also the healing of the community. In

the African context, the discussion of health or well-being has to therefore incorporate “balance or harmony within the body as well as within the social web of relationships that includes the living and the ancestors” (Schmid et al. 2010:137). Kurt Schmid and colleagues further argue that “with this essentially relational view of what constitutes life and well-being, it is not possible to separate religion and health any more than it is to separate the health of individuals from the well-being of their community, their environment or their ancestors” (2010:137). Magezi (2006:507) makes a distinction between community healing from the traditional view of the extended family and the church community that he calls *koinonia*. He argues that this differentiation is important because these communities borrow and influence each other, even though their worldview and resources are different (Magezi 2006:507). According to Malidoma Patrice Somé (1999:22), healing, ritual and community are significantly linked in African society. So, if sickness has a communitarian aspect, it follows also that healing will take the same communitarian form. To heal an individual, the community has to be healed. Magezi states that in Africa:

Everything revolves around the community where human relationships, conduct and moral integrity are constantly moulded, checked and controlled. Where there are misunderstandings or broken relationships that could lead to distress or illness, the community determines the process of guidance and counselling, which is often public as opposed to private. The community is the counsellor, healer and advisor (2006:512).

Members of the community must therefore “ensure always that correct relationships are maintained, starting with the nuclear family, moving outwards to the extended family, the clan, the tribe, gods and spirits to restore the balance of the community” (Magezi 2006:513).

Bringing health to an individual is also the duty of the entire community – the health of one means the happiness of all “because when Africans celebrate through dancing they have fun together and when death transpires, all are in sorrow together” (Magezi 2006:513). Healing enables sick people to be fully human in relation to their society, environment and themselves, but it is only through ritual ceremonies that the necessary attention and healing is received by a person. The treatment of any illness can consequently only happen through ritual purification, exorcism or sacrifices. Bosch-Heij (2012:36) adds another aspect by arguing that the *Ngoma* (drum) as a ritual therapeutic institution offers the means to understand one’s affliction helped by the community that sings and beats the drum. The aim of all the people involved is to remove the person’s suffering and renew

their relationship to the community. The importance of the *Ngoma* therapy, regardless of how it is done, is assured because the community shares the illness and supports the victim, even though not all in the community may be related (Bosch-Heij 2012:37). The family or the community undertakes the journey to recovery with the sick person, though the outcome of that journey may be death. In Africa, unlike in the western mode of healing, a sick person is never alone in the isolation room, intensive care unit, or hospice. Recovery and cure, therefore, acquire a new dimension: it is not the individual sick person who has to be cured in the first place, but rather the broken ties and relationships (Louw, 2008:157). Connected to the communitarian agenda of healing, Louw argues that health is a systemic issue as it depends on the quality of relationships within the community and harmonious contact with the spiritual world (Louw, 2008:171). Based on the above discussion, it becomes apparent that healing cannot be attained in isolation from the community, family and tribal system. “What has to be healed is not a disease but a community” (Saayman, Willem and Kriel, 1992:38). Therefore, the importance of living in community and sharing life with others in process of healing cannot be ignored – “we are people when we live in community because when we live in isolation, we are a plague” (Mpolo, 1994:19).

In African society, traditional healers have remained an indispensable source of health and healing. According to Elialilia Okello and Seggane Musisi (2015:254), there are six main reasons as to why people in Africa still value the intervention of traditional healers in the course of attaining health and healing :

- Traditional healers possess effective treatments and treatment methods for emotional, spiritual and social issues
- They provide client-centered, personalized health care that is culturally appropriate, holistic and tailored to meet the needs and expectations of the patient
- They are culturally close to the clients
- Traditional healers see patients in presence of their family members hence promoting cohesion and stability
- There are many such healers and they are accessible and user friendly (not arrogant but welcoming and hospitable)

- They deal with cultural illnesses or life concepts that are not addressed by western medicine

The reasons articulated above seem to be similar to those of the mentally ill patients in Mzuzu who flock to faith healers rather than go to a clinic to utilise biomedical healing services. If the church then fails to effectively address a belief grounded in the day to day lives of many African people, they will continue to seek assistance from diviners and other mediums who share their belief in evil spirits but not in the salvation of God (Louw, 2008:176).

The mentally deficient person is presented as one of the special problems to be faced in Malawi. J.W.M. van Breugel (2001:85) documents the common belief that Mizimu (spirits) may possess a person, hence such a person has to be taken care of by tying a big wooden log to their feet or their shoulders in order to restrict their movement. This way of restricting a mentally ill person may be deemed as one of the punitive treatments so common to sub-Saharan Africa (Crabb et al. 2012:4). The healing of such special cases, says Breugel, is achieved through the traditional intervention of the diviner (*woombedza ula*) (2001:233) and the medicine man (*sing'anga*) or magician (Breugel 2001:246). Once again, Berinyuu has this to say on African healing:

A sickness of any person can be as a result of an inappropriate doing by a member of the family or a quarrel among family members who are at the time deceased. As such, the therapy communicates that something wrong has been done and the community is responsible, has confessed the guilt through the ritual. If it was a past conflict, descendants of the parties who gave rise to the conflict do the confession on behalf of the dead (1989:63).

The discussion on the understanding of illness in some African cultures shows the communitarian aspect that is connected to the life of an individual person. This understanding plays a role in terms of decisions that an individual in such circumstances has to make.

1.14. The Geography, Economy and Religion of Malawi

Malawi is historically and geographically defined as a landlocked country with no access to the sea or ocean. Formerly known as Nyasaland, the British colonised Malawi and it only attained its

independence on 6 July 1964. The country is bordered by Tanzania to the north, Mozambique to the east, south and south west and Zambia to the west. As a country, Malawi is 855 km long with a varying width of 10km to 250km, covering a total area of 118,484km, with 20 percent of the country covered by Lake Malawi (Malawi Housing Population Report 2008). The Malawi Housing Population report further indicates that the country is divided into three administrative regions having 28 districts in total: there are six districts in the northern region, nine in the central and thirteen in the southern region. In terms of ethnic groupings, the north is predominantly inhabited by the Tumbuka and Ngonde while the Chewa dominate the central region and the Yao, Lomwe and Sena are found in the southern part of the country. All Malawians speak and understand the Chewa language which is spoken in the central region. The Chewa language is also taught in all schools in Malawi at primary, secondary and tertiary levels.

Economically, Malawi belongs to two regional groupings and is listed as one of the seven countries that belong to both the Southern Africa Development Community (SADC) and the Common Market of Eastern and Southern Africa (COMESA) trade blocs. Malawi is also a member of the African Union (AU) and the Commonwealth (United Nations Development Program Country Information)⁷. Based on the latest (as of Tuesday, June 19, 2018)⁸ estimates, Malawi has a current population of 18, 822, 457. The Human Development Index Report (2014) further states that eighty five (85) percent of the population live in rural areas and that the poverty head count ratio is at 50.7 percent of the population. The country's life expectancy at birth is 54 years. Malawi is rated as one of the least-developed countries globally with an agriculture based economy depending on four major cash crops: tobacco, tea, cotton and sugar mostly cultivated through subsistence farming.⁹

Religiously, the United States Department of States (2015:1) quotes the 2014 Malawi Development Goals Endline Survey (MDGE) and reports that "18.5 percent of the population are Catholic Christians, 15.5 percent identify as Central Africa Presbyterian, 13.3 percent as Muslims, 5.6 percent as Seventh-day Adventist and 1.9 percent as Anglican. Another 39.9 percent fall under

⁷ www.mw.undp.org/content/malawi/en/home/countryinfo.html.

⁸ <http://countrymeters.info/en/Malawi>.

⁹ www.mw.one.un.org/country-profile.

the ‘other Christians’ category while 0.8 percent declared another religion and 4.4 percent are atheists.” In summary, the survey concludes that there are 82.4 Christians while Muslims make up 13.3 percent and traditional and others religions together account for 4.4 percent.

1.15. Positioning the Research in Gender, Health and Practical Theology

This research project is located at the intersection of three disciplines: gender, health and theology – more specifically, practical theology as pastoral care and counselling. Of late, gender studies with an emphasis on feminism have come into the limelight. As stated earlier on, the main goal of feminism and gender studies is to be critical, contextual, constructive and creative in resisting ideologies and societal structures that marginalize and oppress certain members of the community (Watson, 2004:4). In deconstructing oppressive and discriminatory structures and transforming them into just relationships, the oppressed people in a society gain a voice and can claim their rightful place in that society. In addition, Ackermann (1996:34) talks of feminist practical theology as a feminist theology of praxis which offers “critical, committed, constructive, collaborative and accountable reflection on theories and praxis of struggle and hope for the mending of creation based on the stories and experiences of women/marginalised and oppressed people”. Promoting the health and wellbeing of all people, especially those suffering from mental illness, is critical to this study. It argues that the church evangelizes through the provision of different social services to people. This includes healthcare. As such, the mission of the church fails when it cannot address issues that threaten the health and well-being of its people.

In view of the above, this thesis is done within the Gender, Health and Theology programme,¹⁰ which takes intersectional and interdisciplinary approaches seriously instead of viewing them as difficult and superficial (Shepherd, 2002:6). Pastoral care and counselling engages with people who are suffering and enables them to live with hope and human dignity (Louw, 2008:15).

¹⁰ The Church of Sweden established the Gender, Health and Theology Programme in 2012 in collaboration with four universities in Africa: Stellenbosch University (SU) and the University of Kwa Zulu Natal (UKZN) in South Africa, the Ethiopian Graduate School of Theology (GEST) in Ethiopia, and Tumaini University Makumira (TUMA) in Tanzania. The main focus of the program is the well-being of women and children in Africa. Since the aim of rolling out the programme was to contribute to achieving Millennium Development Goals 4 and 5, the nine current students at SU are the last to be enrolled as the programme’s focus has now shifted from a pilot phase to sexual reproductive health and rights in Africa.

Therefore, the praxis of theology should be life-affirming in that it allows life to flourish while at the same time resisting those aspects that deny life. Reiterating my earlier findings that most of the patients are women and the fact that mentally ill people have no voice, the exclusion of pastors from the healing ministry to mental patients may be seen to be a matter of gender oppression and marginalization, leading to patients' relapse and inflicting burden on their caregivers. Given its focus on mentally ill people, this thesis is certainly located in the fields of health and practical theology as far as pastoral care and counselling is concerned.

1.16. Key Terms/Conceptualization

1.16.1. Pastors

This study uses the word “pastor” to refer to men and women who are leaders of non-Catholic denominations, most notably Pentecostal and Charismatic churches. They are revered figures of success who lead the worship, are actively involved in faith healing prayers, perform miracles and are culturally recognized as a source of expansive power (Daswani, 2016:110). In this research paper, pastors will also be referred to as traditional healers in comparison to the western biomedical model of healing. The study recognizes that there are faith healers who discern the will of God in conducting their ministry. Some of these pastors admit that they can heal certain diseases but refer others to western biomedical healing. Other pastors claim to heal any type of disease and are usually against any intervention involving the western medication. According to a study in Tanzania, such pastors are business minded rather than having the intention of helping people (Muela, Mushi and Ribera, 2000:299). In reference to the care they provide in the hospital set-up, pastors are known as chaplains.

1.16.2. Traditional Healers

The World Health Organisation (2011:7) defines a traditional healer as someone who is recognized in his or her community as well as other communities as competent in providing health services, using plant, animal and mineral substances as well as other methods based on his/her social, cultural and religious background. These traditional healers depend on their communities' prevailing knowledge, attitudes and belief systems regarding well-being, diseases, sickness and disability (Akyeampong, E., Hill, A.G., and Kleinman, 2015:250). As indicated above, pastors and

faith healers, though their healing system does not resemble that of a typical traditional healer, will nonetheless be identified as traditional healers in this research essay as a way of distinguishing them from the western biomedical healing system. It is therefore important to note that, while this study makes use of this term, Christian healers deny any association with traditional healers and they consider the sangoma to be a devil in a league with Satan (Dube, Shoko, and Tabona, 2011:159ff).

1.16.3. Relapse

Relapse is defined as falling sick again after experiencing a certain period of good health in the wake of being discharged from the hospital. This is basically the return of the signs and symptoms of a sickness after its initial remission. Ascher-Svanum et al., (2010:2) defines a mentally ill person as having relapsed following any of the following circumstances: “psychiatric hospitalization, use of emergency services, use of a crisis bed, or a suicide attempt.” John Csernansky, Ramy Mahmoud and Ronald Brenner’s definition of relapse has more conditions like psychiatric hospitalization; an increase in the level of psychiatric care; deliberate self-injury; suicidal or homicidal ideation that was clinically significant in the investigator’s judgment; violent behaviour resulting in clinically significant injury to another person or property damage; or substantial clinical deterioration (2002:17).

1.16.4. Saint John of God/The Order/Centre

The Brothers of Saint John of God¹¹ who are the proprietors of Saint John of God Mental Hospital in Malawi are officially known in the Catholic Church as the Hospitaller Order of the Brothers of Saint John of God or just the Hospitaller Order (O.H.) founded in 1572. They are also commonly referred to as the Brothers of Mercy, the Merciful Brothers and *Fatebenefratelli* in Italian (the Order’s headquarters being in Italy) which translates as “Do-Good Brothers”. They are known for their hospitality and willingness to welcome strangers, the poor, the rejected and the least of the people in the society who should be uplifted and have their potential realised as is the will of God (John 10:10). All the co-workers who join the brothers in caring for the clients are identified as

¹¹ <https://www.sjog-na.org/who-we-are/>.

Hospitallers. In this research paper, the term Hospitaller will be used to refer to the hospital (centre) but also to the brothers and the co-workers engaged in the mission work.

1.16.5. Pastoral Care

Louw defines pastoral care as “the theological theory known historically as *Cura Animarum*, the cure for souls” (Louw 1998:6). Louw further argues that “pastoral care is a pastoral therapy because it signifies a healing dimension as resulting from God’s gracious action towards his people” (Louw 1998:6). In this case, pastoral care includes the dimensions of support, change and growth as an inherent part of the consoling and transforming event of the fulfilled promises of the gospel. These fulfilled promises of God are known as promisiotherapy (Louw, 2015:490ff). Practitioners of pastoral care characteristically show concern, empathy, compassion, kindness and love as they care for believers through a therapeutic approach that encompasses “healing, sustaining, guiding, reconciling, nurturing and interpreting/assessing” (Louw 1998:7). Based on my understanding Paul in Colossians 1:20, I suggest that salvation should be comprehensive in nature and include the component of healing, hence the need for pastoral care.

1.16.6. Healing/Cure

Louw (1998:54) defines healing as “therapeutic effect, recovery, transformation, well-being, peace, freedom, understood as restoring, reconciling, anti-destructive, anti-chaotic dynamism of the Kingdom of God.” Richardson (2009:193) differentiates healing from cure by saying that cure is “operational, measurable and narrow” while healing is “wide and subjective.” This shows that cure can be part of healing, but it is not necessarily so. Healing is directed toward an illness; it is the attempt to provide personal and social solutions to the problems in an individual’s life that are created by sickness.

1.16.7. Illness

This is a blanket term used to label the real human experience of being affected by disease. This happens to be a special concern of medical anthropology through which specific attention is paid to illness. As such, “illness may be looked at not as a reality but an explanatory concept that

describes the human perception, experience and interpretation of certain socially disvalued states including but not limited to disease” (Pilch, 2000:25). An African perspective on healing shows us that “illness is both a personal and a communal reality and therefore, in a wider sense, a cultural construct affecting different facets of a human being” (Louw, 2008:107-108). This research work uses the term illness as discussed and defined by Louw in section 1.13.3.1 above, (An African Understanding of Illness).

1.16.8. Mental Illness/Disorder

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) states that

there is no definition that can capture all aspects of mental disorders but that the definition should at least have the following elements: a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning (American Psychiatric Association, 2013:20).

All mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. This research project uses such a broad definition of mental illness/disorder without actually qualifying any type of mental illness specifically. After a patient has undergone treatment, they attain a status of health which the World Health Organisation (WHO) defines as a “complete state of wellbeing in which the individual realises their own abilities, can work productively and fruitfully and is able to contribute to his or her community”.

1.16.9. Evangelize

To evangelize is to preach the gospel, especially to non-believers, in an attempt to introduce them to Christ and encourage them to accept him as their saviour (Hluna, 2004:324). David Bosch (1991:66) refers to evangelisation as “disciple making” or the “propagation of faith” (1991:1). More specifically, Bosch defines evangelism as a “proclamation of salvation in Christ to those who do not believe in him, calling them to repentance and conversion, announcing forgiveness of sin and inviting them to become living members of Christ’s earthly community and begin a life of service to others in the power of the Holy Spirit” (1991:11). This study uses the word

“evangelisation” in an extended sense to denote the preaching of the gospel with the aim of converting non-believers to the Christian faith, sustaining and nurturing converted Christians in that faith and preaching or offering a social service to attract people of other denominations to the preacher or a service giver’s denomination.

1.17. Conclusion

Saint John of God Mental Hospital is a Catholic institution that has responded to the need of people suffering from mental illness by operating a mental hospital in Malawi since 1994. One of its policies is that pastors of other denominations are not allowed to conduct prayers in hospital with the patients, unless a particular patient calls for such services through the Pastoral Care Coordinator. This restriction has led to patients and guardians requesting faith healing prayers from these excluded pastors of other denominations once the patients are discharged from hospital. This results in antagonism between the hospital and the pastors in question and can cause patients to relapse when they are told to stop taking the medication provided by the hospital and instead have faith and believe in the healing that God offers through prayer. Located at the intersection of the disciplines of gender, health and theology, this chapter has introduced the research topic and the Malawian mental health landscape, provided the methodology of this study, discussed the theoretical framework and defined the key terms used in the research. It suggests that a biomedical approach to mental health alone fails as a holistic solution to providing treatment and healing in an African context.

Following on from this chapter, the first part of Chapter Two employs Osmer’s framework in dealing with the descriptive empirical task and responding to the question: What is going on? As pointed out earlier on, this first part uses the descriptive-empirical task not in the sense of the systematic gathering of data through field research but in the presentation of the relevant existing secondary empirical resources such as Saint John of God Hospital Services’ policy documents. The aim is to present, discuss and analyse these policies in leading up to the second part of Chapter Two which uses the interpretive task of practical theology to suggest reasons as to why pastors are not involved at Saint John of God Mental Hospital.

2.3. The Curia Pastoral Care Policy for Saint John of God Hospitaller Services

The Curia policy document guides the actions and operations of the services of the Hospitaller Order of Saint John of God worldwide. It was in the mind of John of God, the founder of the Hospitaller Order, to give a spiritual physician to all people who are suffering in order to heal their souls before they find a cure for their bodies (Coleman, 2013:74, Eleanor, 2017::13). It is in this respect that pastoral care to the sick becomes one of the major ways in which the church's presence is felt in the world of health care. Pastoral care is available in order to treat and assist people, to accompany them, evangelize and save them through Jesus Christ the Good Samaritan of the entire human race. The RCC is a universal church with followers all over the world. As such, most of its operations are internationally applicable. It is from such an approach that in 2012, the Hospitaller Order published a policy document called "Pastoral care to the sick and social pastoral care" as a guide for performing its mission with an ever more acute awareness and responsibility (Forkan, 2012:6). As the person behind the Curia policy, Donatus Forkan recognizes that Saint John of God needs to adopt a holistic approach to those who are sick and needy in today's global world where Christianity seems to be declining. He urges pastoral care staff members to have an ecumenical aspect to their pastoral care ministry in view of religious pluralism, so as to offer all people appropriate pastoral accompaniment, regardless of their religious beliefs in these changing times in which new and challenging needs arise (2012:6). The document that was produced through the efforts of the entire family of Saint John of God in 53 countries, covers all areas in which the pastoral care ministry is provided in the centres managed by Saint John of God and is intended to be used by all people involved in the pastoral care ministry of the Order. Forkan further notes in the Curia policy document that it is the duty of the Hospitaller family "to set about providing carefully prepared spiritual and religious assistance to the sick, their families and the people who work in the centres" (2012:8).

Apart from preaching the word of God directly, the church uses schools and hospitals as centres of evangelisation. Saint John of God Hospitaller Services' major inspiration for running all the centres across the world is to be part of the church's evangelizing mission. In essence, the Order's centres belong to the church and therefore have "a mission of evangelizing to the sick and to the needy through a model of comprehensive care based on the example set by Christ and Saint John of God" (Forkan, 2012:24). The policies and guidelines stipulated in the policy

document are therefore aimed at the entire Order as it exists in 53 countries and geared towards contributing to the evangelizing mission of the RCC. It is not in the interest of this study to embark on a detailed analysis of this 143 page policy document. Instead I will present and later offer a critical analysis of the policies related to chaplaincy, religious and spiritual care and health care for people experiencing mental health difficulties. While Saint John of God Hospitaller Services has been in existence for more than 500 years, the discipline of pastoral care was only instituted 36 years ago (in 1982) for the sole reason of sensitizing the brothers to the problem of providing religious and pastoral care to every province. This policy and guideline book was first published in 2012. It is a product of the international meeting on pastoral care of the sick that took place in Rome in November (5-12), 2012.

As a whole, the Hospitaller Order recognizes that patients have needs beyond mental illness, needs that involve different dimensions for which care is provided by staff members (Forkan, 2012:9). Ordained ministers, deacons, co-workers and volunteers who provide pastoral care have to accord patients the autonomy to profess their faith freely (Forkan, 2012:9). Furthermore, the document states that the pledge of hospitality¹² sanctions all the brothers to serve God and perform pastoral care in order to commit themselves to bearing witness to the gospel, proclaiming the word and celebrating the sacraments. The document is firm and specific on how to transform the places where Saint John of God operates into meaningful places of evangelisation (Forkan, 2012:11). The policy recognizes that the future of pastoral work will demand an increased commitment to and focus on evangelizing in the world of health care because it forms a fundamental part of the Hospitaller family's mission (Forkan, 2012:12). The document further notes that: today, the health care culture is not protected from a series of "serious contradictions and ambiguities because of abortion, euthanasia and practices which conspire against the human person"(Forkan 2012:12). The evangelisation practiced "in our facilities, which are defined as Catholic, must contribute to fostering a culture of life, restoring health and providing information for people who are really committed to offering pastoral care" (Forkan, 2012:12).

¹² Hospitality is defined as a welcoming openness to all, to the familiar and the mystery of self, people, ideas, experience, nature and to God. Hospitality is one of the five core values of the Hospitaller Order of Saint John of God. Others are: Compassion, Respect, Justice and Excellence. Being core to the mission, Hospitality is also one of the vows that brothers take others being vow of obedience, vow of celibacy, vow of chastity and the vow of poverty ('St John of God Health Care 's Mission', 2014:3).

Once again, there is an emphasis on the Order's primary mission as the evangelisation of "all the people in health care and social centres which starts by paying comprehensive attention to and treating the sick and needy" (Forkan, 2012:13). Such evangelisation is achieved by practicing hospitality, by specifically reading the gospel of Jesus Christ with a focus on mercy and hospitality and through the specific gifts which John of God received and passed on to brothers and co-workers of the Order. Evangelisation is therefore the basis and the foundation of the mission of Saint John of God, understood as following of the footsteps of Jesus and the Good Samaritan (Luke 10:25) who passed through the world doing good to all (Acts 10:38) and healing all manner of pain and suffering (Acts 4:32) as John of God did by devoting himself totally to the care and service of the poor and the sick.

Forkan writes that "hospitality practiced in the way of Saint John of God is evangelisation" (Forkan, 2009:13). Consequently, in all the hospitals and centres bearing the name of Saint John of God, members of staff must make sure that the management structure, the style of care, policies for human resources, training, formation and the organisation as a whole is geared towards achieving the purpose and the ultimate mission of evangelisation (Forkan, 2012:15). This then calls on all employees to be oriented to be evangelists in the broadest sense of the term, as "evangelisation and pastoral care is not the sole responsibility of the spiritual and religious care services in each Centre, but of all the people who perform the Order's mission" (Forkan, 2012:16). It is interesting to note that there is a special calling for those working at the centres of the Hospitaller Order of Saint John of God and that, through evangelisation, they can become a "sounding board" on "which the melody of the Gospel rings out in many different forms, both through words and deeds touching the hearts of many people and influencing their lives" (Forkan 2012:16). Whatever the case and the experience of patients and co-workers at the hospital, evangelizing through hospitality is a specific feature of the Order.

Evangelisation aside, it is the Order's policy to "respect the freedom of conscience of the people for whom we care and of our co-workers, but we also demand that the [Catholic] identity of our apostolic centres be respected at all times" (Forkan, 2012:15). This is further explained when the document addresses the topic of spirituality by saying that spirituality is one of the pastoral services. Through it, the Order offers pastoral services, evangelisation, ecumenism and support to members of other religions and cooperates with the parishes and dioceses of other faiths. Quoting the general statutes of the Order (2009:53c), the policy handbook states that "all the apostolic workers of the Order are mandated to provide spiritual and religious

assistance endowed with necessary time and material resources”. It further lists specific people who have to provide this care, namely “the brothers, priests, other religious [Catholics] and co-workers” who have the appropriate training and qualification in the area of pastoral care (Forkan, 2012:17). Likening Jesus to the Good Samaritan in the biblical parable found in Luke Chapter 10, where Jesus chooses to take the side of the oppressed, the marginalised and the disinherited, the Order encourages its co-workers, especially those in the Pastoral Care Department, to do likewise. All staff members are encouraged to act as neighbours to those who have no one, to those who have been deprived of all humanity and dignity and especially to those who practice other faiths (Forkan, 2012:35). The Hospitaller Order is aware that it exists in a complex society with different orientations. As such, pastoral care today must be practiced by respecting the freedom and the real life situation of every individual. The policy is firm in pointing out that “we must deal with the spiritual needs of all the sick and the marginalised, respecting them and their freedom, without trying to be heroes or protagonists and giving them what they need to the extent that we are able” (Forkan, 2012:35). There are also people who visit the centres of Saint John of God who do not identify with any specific religion. In this sense, the Order states that “it shall concern itself with the spiritual growth of all its clients and patients, while supporting those on a specific religious path”(Forkan 2012:39). In such circumstances, the policy argues that “it is not necessary to have an ordained minister, a priest or a person appointed by the bishop to accompany an individual who is suffering from a spiritual point of view” (Forkan, 2012:40). While there is such an emphasis on not engaging an ordained minister, patients have to rely on the Catholic chaplaincy of the Centre for their spiritual support.

The Saint John of God ministry is not limited to hospital services, let alone mental hospitals. It operates different services in more than the 390 centres in 53 countries across the globe. It is from such a background that this policy document encourages pastoral care to be done according to specific sectors and needs, bearing in mind that “it is not possible to have a one-size-fits all answer to the many and varied needs of the service users” (Forkan 2012:40). The recommendation that pastoral care should be provided according to sectors, as discussed later on, is missing in the Malawian policy document, hence it excludes pastors of other denominations from the provision of mental health care. The curia policy points out that the “spiritual and the pastoral care teams needs to differentiate between and take account of the different kinds of patients and services available in the Centre” (Forkan, 2012:41). This implies that each of the sections of mental health, physical disability, general hospital, services to the

elderly, the homeless, the terminally ill and the street children, must have a specific pastoral care plan drawn up. Furthermore, the complexity and diversity of patients mean that professional staff members require adequate specialization in order to respond to the real spiritual needs of the sick in different sectors.

In all the centres, the Order appreciates the fact that it is operating in contemporary society, hence the need to be attentive to people belonging to other faiths and religions. On this matter, it says that “in our hospital, we encounter people who apart from having an entirely different code of ethics, also have different faith and religions, as well as some who are non-believers, agnostics and atheists” (Forkan, 2012:43). The policy welcomes all people, Catholics and non-Catholics, in the spirit of hospitality and provides care to them while collaborating actively in promoting pastoral health care in the local church. It further states that “the attention given to people of other faiths by the staff members of Saint John of God Hospital cannot be delegated to a representative of another religion without any form of proper dialogue aimed at bringing positive understanding to people of other faiths” (Forkan, 2012:44). Indeed, the policy document affirms that the centres act as the church’s frontier in that the people who visit them have had varied experiences of faith and the church. The patients “are sometimes disappointed and may have acquired an excessively critical attitude towards the Catholic church or, they may be in search of the truth or have altogether adopted an atheistic stand”(Forkan, 2012:46). Forkan urges that all members of staff should involve patients as main players in choices concerning their health during pastoral care and therapeutic processes (2012:46).

The second last section of the policy deals with the religious and spiritual care services offered to patients. In this section, the Order admits the fact that chaplains today “are increasingly encountering non-Catholics, who seek religious care from other denominations and faiths” (Forkan 2012:47). It is from such an understanding that the Order advises that the members of the chaplaincy department “offer these clients the possibility of receiving spiritual assistance from ministers of their own denominations and faiths and that, when the circumstances require and permit, there should be deliberate opportunities for dialogue and ecumenical celebrations”(Forkan 2012:47). With respect to patients with mental illness, their condition and circumstances limit them from seeking religious care from pastors from their respective denominations. Although there is a hospitable spirit towards people of other Christian denominations, the policy quotes the Catechism of the Catholic Church (CCC: 1421) that says that “Jesus Christ is the real salvation of all the patients, both in their bodies and souls, hence

patients should avail themselves for the sacrament of reconciliation (Penance), the anointing of the sick and the Eucharist” for them to experience real healing”. It is in this regard that the chaplaincy has to cooperate and coordinate with the general pastoral ministry and with the pastoral care of the sick, both in the local parish and the diocese to which the Centre belongs. The people in the chaplaincy department have a responsibility to be in touch with all the patients’ [guests]¹³ home parishes. To become a member of the chaplaincy department, one needs adequate theological and pastoral training together with social skills and knowledge of interpersonal relations. Members of the chaplaincy department must, therefore, be familiar with the spiritual and pastoral wealth of the Hospitaller Order in order for them to make a valuable charismatic contribution to their pastoral work.

Lastly, I present the policy on pastoral health care for people experiencing mental health difficulties in Hospitaller Centres. This is an area with which the current research is specifically concerned. Saint John of God, together with other church organisations, respond to mental suffering and has its own way of preaching the gospel, representing charity in its most notable form. The policy notes that “the last are first among us and the medical establishment, people experiencing mental health difficulties are considered last” (Forkan, 2012:91). Saint John of God regards its ministry to mentally ill patients as a special one compared to the services offered to other people who come for help at the Centre. Forkan (2012:91) makes it clear that pastoral care is different in a mental hospital as it uses a method of evangelisation that starts by establishing significant relationships aimed at helping whoever is in a difficult situation. It is the mental patients who have a special need to be engaged in outings, pilgrimages and cultural visits that allow them to gain new experiences and tests them outside their normal environment. The policy explains that mentally ill people seek support but they want to be the ones to decide when to allow someone to approach them. In this regard, staff members have to allow these patients to move at their own pace (Forkan, 2012:92). With regard to spiritual care, the policy stresses that whoever wants to preach the gospel to these men [and women] needs to be acquainted with some elements of their psychiatric background.

¹³ The policy document uses the word guests to refer to all patients and service users.

CHAPTER TWO

AN ELUSIVE POLICY DOCUMENT: THE IMPACT OF THE EXCLUSION OF PASTORS ON MENTAL HEALTH DELIVERY

2.1. Introduction

The goal of this chapter is to present and discuss the impact of the exclusion of pastors in mental health healing at Saint John of God Mental Hospital. While the exclusion policy is directed at the pastors, it has a direct effect on patients and their caregivers. As stipulated in Chapter One (1.9.1), this research work is influenced by the four tasks which Richard Osmer advocates as constituting a good model for doing practical theology (2008:4ff). As such, in relation to the policy that is in use at the hospital, this chapter uses both the descriptive empirical and the interpretive tasks of practical theology with the aim of responding to two questions: What is going on? And why is it going on? The descriptive empirical task, which is based on the image of priestly listening, provides a platform from which to understand the effects of the exclusion policy on patients grappling with mental illness. As document analysis research, the chapter presents the policy document as analytical data for evaluation and reflectively interprets the reasons behind the implementation of such a discriminatory policy in order to understand the exclusion of pastors at Saint John of God Mental Hospital. Apart from my discussion of the policy, this chapter also engages the interpretive task of practical theology proposed by Osmer to propose possible reasons for the exclusion of pastors from the mental healing mission. Consequently, the recommendations discussed in Chapter Five depend on the discussion of the policy document in this chapter.

As stated in the previous chapter (1.16.8), this chapter does not qualify the types of mental illnesses in question, but rather mental illness is generally understood as a “syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (American Psychiatric Association, 2013:20). As such, all behaviour associated with significant distress or disability in social, occupational, or other important activities is classified as mental illness in this study. The policy that excludes pastors from the healing ministry of mental illness at Saint John of God Mental Hospital does not affect the pastors, but directly affects the patients. Those most

affected are women who suffer both as patients and caregivers. The weight on women emerges against the cultural background of a traditional African society where women are culturally constructed as caregivers. The women mental patients are therefore vulnerable in the sense that they are expected to take on a caring role despite their compromised mental health. Generally, oppressed and sick people are desperate and will resort to any remedy that offers hope of healing (Dube, Shoko, and Tabona, 2011:184). In the case of mental patients at Saint John of God, discharged patients on long term medication from the hospital, are tempted to consider faith healing. This marks a major shift in their approach to their illness because faith healing services are not offered as an option in the hospital and therefore functions as an alternative rather than a complementary treatment. Many patients therefore end up relapsing after going for faith healing prayers where they are challenged to have a strong faith in God and to stop taking the medicine prescribed by the hospital (Anderson, 2009:529). My analysis of women's inclination towards faith healing is informed by Martin Khoaseb's argument that, in comparison to men, larger numbers of women visit pastors in search of healing miracles (2014:137). Khoaseb's research noted that most denominations are composed of women and children (2014:137). Likewise, nineteen (19) of the twenty-five (25) participants in his study, were women.

This chapter will firstly attend to the description of the policy before discussing the three policy documents: the Curia¹⁴ pastoral care policy, the provincial pastoral care policy and the Malawian pastoral care policy. Next I will provide an analysis of the three policy documents and discuss the impact of pastors' exclusion from the healing ministry of Saint John of God Mental Hospital. In the final stages of this chapter, I will focus on the burden of relapse from mental illness.

¹⁴ Curia is used to describe the top tier of Saint John of God's administration based in Rome, both as its worldwide headquarters and the hub of the Roman Catholic Church. Below Curia administration, there are provincial administration councils. Currently, there are 20 Provinces: Africa, Andalusia, Aragon, Austria, Bavaria, Castille, Colombia, France, India, Korea, Lombardy–Veneto, Northern South America, Oceania, Poland, Portugal, Rome, Southern South America, the United States of America, Vietnam and West Europe. Malawi belongs to the West European Province.

2.2. Description of Policy

In discussing education policy and social class, Stephen John Ball (2006:43-52) describes a policy as both contested and changing, always in the state of becoming. He further argues that for any text, a plurality of readers must necessarily produce a plurality of readings (Ball 2006:47). Ball's description of the changeability of policy is in line with one of the seven features of postcolonial activities enumerated by Lartey (2013:xvi-xviii). Lartey states that all postcolonial activities "recognize that issues are in a constant state of change and flux" (2013:xvii). Ball continues the discussion that "policies are supposed to be lived and thought about rather than oppressing and limiting people as they are a product of compromises" (2006:44). Douglas Hawks (2017:90), on the other hand, overlooks such changeability and defines a policy document as an organisation-level document that prescribes acceptable methods or behaviour. For him, a policy document directs the procedures and operations of an organisation. Despite divergences in their definitions, both Ball and Hawks agree that all organisations need some level of regular performance among their workers in certain situations hence the need for the existence of a policy (Ball, 2006:44, Hawks, 2017:93). This study aligns itself with Ball's argument that policies are supposed to be lived and thought about rather than oppress and limit people.

The policy that I discuss in this study is found in three related policy documents. The first one is known as "Pastoral Care in the Manner of Saint John of God" (Forkan 2012) which was published in Rome, the headquarters of the Roman Catholic Church (RCC) and Saint John of God worldwide mission. This policy document is meant to govern all pastoral care activities in its more than 390 service centres in 53 countries. I shall refer to this document as the Curia policy document. Secondly, there is a special policy issue called "Policy on Pastoral Care: Companion for the Journey" (Lennon 2004). This policy document is intended for all pastoral care departments belonging to the Hospitaller Order of Saint John of God, West European Province comprising of Malawi, Great Britain, Ireland, and the United States of America (New Jersey). I shall refer to this policy as the provincial policy document. The last policy is a localized policy which was reviewed and revised in 2011 in Malawi and is in use at Saint John of God Mental Hospital in Malawi. I shall refer to this document as the Malawian pastoral care policy.

2.4. The Provincial Pastoral Care Policy for Saint John of God Services

The second revised edition of *Policy on Pastoral Care: Companion for the Journey* (Lennon 2004) is an amalgamation of the original pastoral care policy statement published in 1992 and the standards specific to chaplaincy which came into use in 1996. The 2004 policy edition, which is currently used in all the service centres belonging to the Western European Province of Saint John of God (Britain, Ireland, Malawi and the United States of America (New Jersey)), is the result of a renewal process in pastoral care development coordinated over a period of three years by Saint John of God services in Ireland (Lennon, 2004:5). The provincial of that time (2004), Brother Ronan Lennon, explained that the “purpose of the book, *Companions for the journey*, “is to explain, direct, guide the pastoral care activities of the Hospitaller services in line with the biblical story (Luke 10:25-37) of the good Samaritan” (Lennon, 2004:6). All pastoral caregivers are companions for the journey (Lennon, 2004:6). The thirty-eight (38) paged policy document recognizes that pastoral care is central to the mission and core values of the services provided by the Hospitaller Order of Saint John of God. Indeed, there is a pastoral dimension to all the duties performed by staff members as well as to the specialist services provided by the chaplaincy department.

According to the provincial policy, pastoral care pays attention to the whole person and anyone, whether a layman or ordained, can provide pastoral care. The policy is addressed to all staff members and urges them to adopt a pastoral care approach as part of the daily operation of their respective jobs. As such, a chaplain can be male or female, lay or ordained (Lennon, 2004:8). The duty of the chaplains employed by Saint John of God is to provide religious ministry and in the process, access ministers of other denominations and religions at the request of specific patients (Lennon, 2004:9). Implicitly, this indicates that to be a Roman Catholic Christian is prerequisite to becoming a chaplain at Saint John of God, as is indicated in the job description of the pastoral care coordinator. The policy document also encourages staff members who are not Roman Catholic Christian to still provide pastoral care support to patients. It states that “we recognize that religious freedom is a fundamental human right. The services respect a person’s rights to choose whether they wish to participate in religious activities, to have access to a minister of their own religion and denomination” (Lennon, 2004:9).

Policy three in the booklet is dedicated to religious ministry. It states that Saint John of God provides religious ministry through its chaplaincy departments. The Order as an organisation within the RCC, has a specific obligation to provide Catholic chaplaincy within all its services. These include the celebration of sacraments, prayer reflection, meditation and reading the scripture, worship on all Holy days, blessings and sacramental, memorial services and funerals, ritual and providing information on RCC teaching at all times (Lennon 2004:9). The Provincial policy repeats and stresses the fact that

it recognizes religious freedom as the fundamental human right of all people. As such, people should have a right to choose whether or not they are willing to take part in any religious activities conducted by the Pastoral Care Department. They also have a right to have access to a minister of their own religion and denomination (Lennon 2004:11).

Again, it is the responsibility of chaplains to access ministers and church services from other denominations on behalf of the service users as requested or when it is otherwise appropriate to do so (Lennon, 2004:17). It is in this instance, where the Malawian policy, with its bracket policy document, does not adopt the same inclusive policy as related to the pastors of other denominations.

In the final pages of this policy document, the Order discusses the appointment of a pastoral care team in order to support and facilitate the effective and efficient operation of the Pastoral Care Department. The policy gives guidelines on who should be appointed and how to appoint these members. Specialist staff members who are already working in other departments, like nurses, clinicians, accountants, lecturers, counsellors and rehabilitation assistants, qualify to be part of the pastoral care team. A maximum number of six people are supposed to constitute a pastoral care team (Lennon, 2004:30-32). I now present the final policy document behind the services in Malawi.

2.5. The Pastoral Care Policy and Standards of Saint John of God Hospitaller Services in Malawi

The policies and standards of Saint John of God Mental Hospital in Malawi are an amalgamation of the Hospitaller Order's 1988 policy, the 1992 Quality in Action Manual and Malawian human resources policy, professional codes, good practice and legal requirements. These policies and standards were put together by members of the administration team

(*Policies and Standards of Saint John of God Hospitaller Services in Malawi*, 2011:2) and govern all the services provided by the following departments/sectors of Saint John of God Hospitaller Services in Malawi: House of Hospitality, Administration, Saint John of God Clinic, College of Health Sciences, Services for the Elderly, Addiction and Recovery Services, Institute for Vocational Training (IVT), Umoza Program for Street Children and Child Development Centre (CDC). In this revised document, all the policies for specific departments have been written to correspond to the local Malawian context. In what follows, I will focus exclusively on the 3 pages of chapter 7 that specifically addresses the Pastoral Care Department and excludes pastors from the healing ministry to the mentally ill, since that is aim of my research.

The hospital recognizes that the Pastoral Care Department is central to Saint John of God's mission. Hence there is a pastoral dimension to all the service activities in addition to the specialists services that are provided through the Pastoral Care Department (*Policies and Standards of Saint John of God Hospitaller Services in Malawi*, 2011:57). Indeed, the Pastoral Care Department and its team are there to facilitate the delivery of pastoral care to both patients and staff members. The policy (2011:58) stipulates the department's three objectives as follows: to give spiritual care to the needy, to share the word of God and to provide care and spiritual accompaniment to all co-workers. These three objectives are in line with the Order's mission in that it aims to identify, respond and support the needs of individuals in the manner of Saint John of God.

With regard to religious ministry, the policy states that it "is an essential element of the spiritual wellbeing. As such, there is a provision for clients to access religious ministry through the Pastoral Care Department where clients have the freedom to worship at the church of their choice and to access the religious ministers of their choice" (*Policies and Standards of Saint John of God Hospitaller Services in Malawi*, 2011:59). It is under this policy of religious ministry that I have observed throughout my tenure at Saint John of God Mental Hospital, that all prayers in the hospital are organised and facilitated by the Pastoral Care Coordinator, who is a member of the Catholic Church, the hospital's Catholic chaplain or another catholic priest. Pastors from other denominations are not allowed to conduct prayers in the hospital. However, the Pastoral Care Coordinator can invite other pastors to pray with particular patients at those patients' request. As stated in the background and motivation of this study (1.1), when in hospital, most patients do not have the mental capability to make informed decisions and to

seek for the services of their own pastor. The Pastoral Care Coordinator's job description¹⁵ contains inclusive elements which are not applicable to the mental hospital owing to the nature of its patients' illness. This calls for the revision of the policy in line with the sector directives contained in the Curia policy. The policy (2011:61) further reminds the co-workers in the Pastoral Care Department to professionally offer their pastoral care services in accordance with the ethical teaching of the Catholic Church.

¹⁵ The following is not an exhaustive list of the duties associated with the post but is only intended as guidance for the person assigned to this position:

- Coordinate pastoral care services carried out in the House of Hospitality, Centre for Living, Institute of Vocational Training, Child Development Centre, Venegas, Umoza and Saint John of God Centre – Lilongwe.
- Assess clients' including their family's spiritual needs.
- Assist clients and families in using their faith in dealing with illness, trauma and stress or disability.
- Visit newly admitted clients and those with special requests in assigned areas.
- Provide accompaniment to individuals and groups concerning their spiritual, emotional and other special needs.
- Attending and participating in multidimensional/clinical meetings in the House of Hospitality, Centre for Living, Institute of Vocational Training and Child Development Centre.
- Provide group pastoral sessions to clients in the Centre for Living, Institute of Vocational Training and Child Development Centre and Umoza.
- Provide crisis intervention as necessary in situations like spiritual dilemmas, suicide, hopelessness and other desperate situations for clients.
- In cooperation with staff and clients, assist in organizing morning and weekly worship services for clients and staff across the service in creative and ecumenical ways.
- Visit clients across the service while giving daily priority to those in greatest need.
- Prepare and make arrangements for clients' participation in religious ceremonies of their faith as required.
- Promote awareness among staff about the life of Saint John of God and the core values directing the service. This includes being a role model for staff in promoting the organizational values.
- Initiate and maintain communication with area clergy through consultation, notification of their Faithfull's admission and discharge from the House of Hospitality, including facilitation of clients' access to their religious leaders as required.
- Foster the institution's mission and philosophy as it relates to the pastoral care function/department.
- Represent the institution pastorally to the local community, including public speaking and attendance at social gatherings in the community.
- Conducting probationary induction of staff about the life of Saint John of God and Hospitality.
- Maintain a working relationship between the service and other religious groups or organizations to facilitate holistic spiritual growth.
- Adhere to all organizational standards, policies and procedures and to the code of ethics of the pastoral care workers and professional chaplains.
- Is fully familiar with terms of the service safety, health and welfare policy and ensures that staff, clients and visitors adhere to it.
- Ensures accurate reporting and documenting.
- Undertakes other duties as directed by the Program Manager, Director or designated other.
- Is fully familiar with the rights of people served by the Service and respectful of the same.
- Respects and operates within the ethos and tradition of the Hospitaller Order of Saint John of God.

The House of Hospitality (HOH) is an admission unit for acute mentally ill people that operates under the vision of Saint John of God which states in its contract of care that “our ethos and philosophy reflect our care and concern for the holistic approach”. HOH therefore sees its care as embracing each person’s physical, social, emotional and spiritual dimensions. This approach to care is founded on Saint John of God’s core vision as a society inspired by hospitality, where the potential of each individual is achieved. The policy requires that the client and family is provided with the necessary pastoral support throughout the patient’s stay at the hospital (*Policies and Standards of Saint John of God Hospitaller Services in Malawi*, 2011:85). After considering the three policy documents, I will present a critical analysis of these documents in the following section.

2.6. Critical Analysis of the Policy Documents

The presentation of the three Saint John of God policy documents opens up areas of discussion and interest. The first concerns these policy documents’ dates of publications and revision. The first one (Curia policy) which is an overall policy document for Saint John of God Hospitaller Services worldwide, was published in 2012. The Provincial pastoral care document for the Western European Province to which Saint John of God in Malawi belongs was published in 2004. Lastly, the Malawian policy document under evaluation was published in 2011. The fact that Saint John of God services in Malawi are on the third tier of the organogram means that the Malawian policy document is supposed to be in conversation with the worldwide policy and the provincial policy and consequently have the latest publication date of the three. Yet, the reality is that it is older than the latest provincial policy document. This contradicts the body of rules of the RCC contained in the Code of Canon Law (1983), which dictates that the contents of the two mother documents should be synchronized to fit into and apply to the local situation in Malawi.

The fact that these documents have not been revised and synchronised into a recent local policy brings accounts for many related problems. The Curia policy document puts much emphasis on the issue of evangelisation. This leaves little room for people of other denominations to be involved in the healing ministry offered to those who are mentally ill. There seem to be an unfounded fear that pastors from other denominations will proselytize members if they preach their gospel of healing at the institutions belonging to the RCC. After all, many African people are already attracted to any gospel that gives hope and preaches healing and material wealth

acquisition (Khoaseb, 2014:68). In his public speech in the year 2000, Levi Fragell noted the expansion and explosion of Pentecostal and charismatic ministries that account for a decline in the number of Catholic Christians. He predicts that by the year 2030, Pentecostals will constitute the world's largest Christian denomination. As such, the fear of successful conversion or evangelisation by pastors of other faiths within RCC institutions might not stop people from joining Pentecostal or Charismatic movements. The Pentecostal and Charismatic spirit seems to be a driving force among the people of the world in general and Africa in particular because of a common attraction to the faith healing ministry. As such, Stephen Hayes talks of the accusation made against mostly Pentecostal churches that they do not involve themselves in mission work, but rather proselyte among members of other Christian bodies and in the process 'steal the sheep' from these churches (Dube, Shoko, and Tabona, 2011:183).

All three policies seem to leave a space for people of other faiths to choose to participate in worship or access ministers of their own choice. The Curia policy is more particular on this point by stating that people in the chaplaincy department should take into consideration the sector of the patient they are serving. Generally, most mental patients do not have the capacity and the ability to reason and request the services of their pastors when they are sick and admitted in the hospital. They are also often discharged from hospital as soon as they reach a functional level of reasoning so that they can continue the healing process in their community among their family members. This means that engaging the pastors of other faiths or other denominations is often impractical or impossible.

The policies present conflicting and ambivalent positions. In one line, Curia and Provincial stress priority of Catholic services while in the same vein they seem to open a door for pastors from other denominations, and yet in practice these pastors are denied ministry. There is not only contradiction in the policy but also there exist a gap between policy (theory) and practice.

The implementation of the provincial and Malawian policy documents focuses on staff members from different denominations who have to be incorporated into the pastoral care team. These are not necessarily pastors but rather members of other denominations. As such, these staff member do not usually possess the gift of healing that patients and their guardians are looking for. The pastoral care services in a similar hospital of Saint John of God in Australia seem to function differently and works as proposed by the Curia policy document. At this hospital, the pastoral care team that provides services to patients is composed of professionally

trained pastoral caregivers from different Christian denominations such as Catholic, Anglican, Baptist, Uniting, Pentecostal and Churches of Christ. The pastoral care team has varying theological and counselling qualifications and are certified through Clinical Pastoral Education (Ashton et al., 2016:273). It is therefore not surprising then to read the positive results of a study that aimed to establish how patients experienced pastoral care in this health care setting (Ashton et al., 2016).

With reference to developing pastoral care programs based on the sector involved as the Curia policy document stipulates, the Provincial and the Malawian policy documents are not specific in addressing sector programs. They give a general solution to handling pastoral care issues without considering the type of people who need the service. At Saint John of God Centre in Malawi, for example, there are more than twelve sectors serving the people. Mental health is just one of the departments, yet the policies directing pastoral care services in all these departments are the same. An elderly person who operates from home on a daily basis and accesses and benefits from pastoral care services at Saint John of God does so differently from people with mental health problems admitted to the hospital. Similarly, pastoral care services available to a patient on domiciliary care are completely different to those offered to a child in the street program. All these observations show that there can be no single policy that can effectively respond to the needs of patients in all sectors of Saint John of God Hospital services in Malawi.

The Malawian policy document does not take into consideration the African context in which the hospital is operating. In this regard, the policy neglects two key issues which would facilitate the healing of mentally ill people as discussed in Chapter One. These key issues are based on the teaching of the African Synod on inculturation (1.13.2) and the African understanding of illness and healing (1.13.3). The Malawian policy document has not given patients the room to open up to this richness of Christianity through an integration of the positive values of their culture and the values of the gospel. From this point of view, the policy document lacks the concept of inculturation and hence indirectly denies the appreciation of the cultural values of the people being served. Additionally, the hospital's policy document seems to lack an African understanding of illness and healing. Illness in Africa does not only concern the individual but it is communitarian. If illness concerns the entire community, it follows that the whole community has to be healed or involved in the healing. As such, sustainable healing can only be attained when the community is fully involved at all levels. The community

includes the pastors who influence the decisions of the people in the community as stated earlier on in Chapter One. The fact that some members (pastors) are not involved in the healing process has a negative implication for the sustainable healing of those individuals suffering from mental illness. Writing on the healing of postcolonial trauma in the African experience, Fulgence Nyengele (2017:96) acknowledges the need for the collective actions of the African community for there to be real healing.

Lastly, the constitution of the Republic of Malawi gives freedom of worship to all its citizens (Malawi Government, 2006, chapter 4). In the absence of a sector policy meant to serve the mentally ill people at Saint John of God Mental Hospital, patients may not be experiencing such religious freedom. While the policies allow pastors to offer their services in Saint John of God's centres, the reality at Saint John of God in Malawi is that they are excluded from the healing ministry of mental patients. In order to understand why the pastors of other denominations are excluded from the healing ministry at Saint John of God Mental Hospital, I will next engage the interpretive task (why is it going on?) of practical theology (1.9.1.2) to discuss the possible reasons behind such an exclusion.

2.7. Possible Reasons for Excluding Pastors

In this section, the researcher proposes possible reasons behind the exclusion of pastors from other denominations in the healing ministry of patients suffering from mental illness at Saint John of God Mental Hospital in Mzuzu. The discussion is informed by the motives and aims of missionary churches as documented by David Bosch and also borrows from researchers' own experience as the Pastoral Care Coordinator at Saint John of God Mental Hospital. Quoting Johannes Verkuyl, Bosch argues that there are four "impure motives" for any missionary church activity (1991:5): an imperialist motive, which focuses on turning the natives into docile subjects of the colonial authorities; a cultural motive which aims to transfer the missionary's superior culture; the romantic motive which describes missionaries who have a desire to go far away to what they perceive as exotic countries and people; and an ecclesiastical colonialism motive driven by the missionary's urge to export their faith and church order to other territories. Bosch (1991:5) indicates that apart from the above motives, there are also more appropriate theological motives for missionary enterprises like: conversion,

church planting, and eschatological or philanthropic goals.¹⁶ Based on the practices of Saint John of God Mental Hospital where the researcher has been employed since 2011, it seems clear that ecclesiastical colonialism and conversion motives rank high on its agenda and determine the operations and delivery of its mental health services.

The Catholic Church which governs Saint John of God Mental Hospital is one of the mainline international churches that portrays an ecclesiastical colonialist motive. According to Dube, Shoko and Tabona, mainline churches “often accuse Pentecostal churches of sectarianism, narrow-mindedness and indifference to social ills and riddles of human existence” (2011:170). In this respect, the Catholic Church’s stance is perhaps due to the Pentecostal tendency to local and congregational autonomy (Dube, Shoko, and Tabona, 2011:170). This might inform Saint John of God Mental Hospital’s policy to restrict pastors’ involvement in the delivery of mental health care. Being a missionary organisation, Saint John of God might be caught in a similar situation to that being experienced by most postcolonial churches. Lartey argues that “many churches in Africa find comfort in the colonial ways of the past and never venture out of these captivities into an engagement with their context or challenge the past they have come to hold as true” (2013:xi). He further states that in the postcolonial era “African theologians, religious scholars and church leaders have become neo-colonialists of the discipline and practices, often policing practices of their parishioners with much stronger force than European missionaries ever could or did” (Lartey, 2013:x). It is based on such a background that Lartey proposes a theory of postcolonializing God in which God should be taken as a basis for decolonisation, diversification and a promoter of counter-hegemonic social conditions (Lartey, 2013:xiii). In an earlier critique, Achille Mbembe argues that many leaders in the postcolony are obsessed with the idea of demonizing and remaking the past in their own image without showing concern for the needs of their people (1992:18).

The second reason that Saint John of God Mental Hospital’s policy restricts pastors from being involved in the delivery of mental health care may be based on theories regarding psychosomatic (the relationship between the body and the mind) disorders. In this theory, it is

¹⁶ Bosch provides definitions for these four missionary motives. He states that conversion emphasizes personal decision and commitment, narrowing the reign of God to the number of saved souls. He defines church planting as stressing the need to gathering a community of the committed, but states that such an approach is inclined to identify the church with the kingdom of God. An eschatological motive is explained as a process that fixes people’s eyes on the reign of God as a future reality. Finally, a philanthropic motive is one in which the church is challenged to seek justice in the world but which easily equates God’s reign with an improved society.

believed that a physical disease is caused, or made worse by mental factors such as stress and anxiety. Elias Mporu, on one hand, points out that most “people with African ancestry do not differentiate illness that concerns the body (physical illness) and illness that concerns the mind (mental illness)” (2011:9). Western medical practice, on the other hand, looks at somatization as bodily expressions or emotions that only exist in the mind and that can therefore only be recognized as mental illness (McWhinney, Epstein, and Freeman, 2001:237). With regard to the causes of mental illness, many people are inclined to think that witchcraft or a human agent or religion is responsible for psychosomatic symptoms that mental illness cannot be treated in a hospital (Akyeampong, E., Hill, A.G., and Kleinman, 2015:11, Khoaseb, 2014:70, Chilale *et al.*, 2017:420). In the prologue to her book, Catholic nun and psychologist, Nancy Kehoe says that “the entrenched belief in the mental health community was that therapists could not and should not talk about religion with ‘crazy people’ in order not to influence conversation of clients, not to facilitate and affirm delusional thinking of clients, respecting the separation of church and state” (Kehoe, 2009:xvi-xxiii). The reasons given by Kehoe are not applicable to Saint John of God since it already subscribes to the RCC policy on religion. Furthermore, the fact that most Africans view illness as treatable only in the dynamic framework of human existence explains where they seek help when they are taken ill. Because this African understanding of illness and healing may be common among many pastors, the RCC would not allow them to operate in a mental hospital in order to avoid conflict with the western medical system employed. It is therefore most likely that part of the hospital’s missionary agenda was to reject anything that seemed African when they brought the gospel to Africa. Following Sylvester B. Kahakwa’s proposition, the church might have “come to Africa and built hospitals to heal physical illnesses leaving out the spiritual causes of sickness and biblical healing that is a common practice among Africans” (2004:13). Reacting to what he calls paradigm change, Louw (2008:180) rejects “this authoritarian missionary pattern which regards the western model as superior and the African model as inferior”. Borrowing from Thomas Long, Marthinus Daneel and Emmanuel Milingo’s insights, Louw affirms that “if the church fails to effectively address beliefs so deeply rooted in the daily lives of many Africans, they will continue to seek assistance from diviners and others who share their beliefs...” (Louw, 2008:176).

The third reason that Saint John of God Mental Hospital restricts pastors’ involvement in the healing ministry could be that the hospital administration does not want to give clients the option to seek alternative treatment. Allan Anderson reports in his paper that “many

Pentecostals and members of African initiated churches do not use any medicine because its use may be interpreted as lack of faith or having a weak faith” (2009:526). In the same vein, giving patients access to means of healing alternative to the ones provided by the hospital may be interpreted as the failure of the western medicine propagated by the hospital. Anderson gives a personal testimony on how he was healed through prayers after contracting cerebral malaria in the mosquito infested district in southern Malawi. He says that after failing to access medicine for two days, he became weak and felt that he was dying. Through a prayer offered by a Christian villager, he was healed and a doctor testified using laboratory tests that he caught malaria and now he has been healed. The second incident that Anderson provides as evidence concerns a road accident that left him and his wife dying. Even when the doctor treating them was sure that they would not recover, they were both miraculously healed after a Catholic priest and Catholic and Lutheran nuns prayed for their recovery. Anderson attributes this recovery to the power of healing prayers.

Related to this reason is the outcome of a study conducted by Harvard University on the effectiveness of intercessory healing prayers published in April 2002. Starting with the widespread belief that prayer heals the sick (Dusek et al., 2002:577), the final analysis in the study shows that the people having bypass surgery who were told that they will be prayed for and were actually prayed for had the worst clinical outcome when compared to two other groups who were told that they might or might not be prayed for (Dusek et al., 2002:577). While not doubting the effectiveness of prayers on patients, one can conclude from such a study that a patient’s healing does not depend on the prayers offered. Rather prayers have a placebo effect¹⁷, on the people being prayed for. While it is not the intention of this project to go into details in order to explain the theories behind placebos, it is clear that in the medical field, a placebo has a connotation to cheat but has played a significant role in effecting certain types of treatments related to psychosomatic and psychiatry as extensively discussed by Khoseab (2014:168ff). The RCC then may not allow pastors or faith healers to come to the hospital as pastors may deal with people who may say they have been healed on the basis of their pastor’s word without actually being healed. The discussion of the placebo effect triggers questions as to whether faith healing prayers are real or are meant to cheat people.

¹⁷The placebo effect is based on the belief of the patient and not necessarily in the treatment action itself. The medical personnel uses the placebo effect to entice their patients into believing that they have been healed while in reality no treatment has occurred.

The last possible reason for excluding pastors may be the self-acclaimed superiority of the RCC over ‘small’ churches. Western Instituted Churches, among which the RCC is one of them, generally assumes ecclesiastical superiority over African Initiated Churches. The obvious reason for such superiority is usually connected to its establishment, funding, and the social services that they provide to the people in the country. It must be noted that the issue of ecclesiastical superiority is essentially an ecclesiological one. The superiority attitude of RCC clergy/laity derive from a historic Catholic attitude that rest on their understanding of the church is relation to the Protestant Churches¹⁸. Related to the issue of superiority, the RCC preaches that it has all the necessary tools for its members to attain healing. In this regard, through its priests, the RCC administers sacraments of healing. These sacraments are different from other faith healing practices. While sacraments of healing are administered to RCC patients who may be healed or offered as preparation for an impending death, faith healing prayers are offered to any person who is in search of healing and has hopes of recovery. Both the RCC and other faith healing ministries base their healing on biblical passages like James 5:14-15, which dictate that one who is sick “must call elders of the church to pray for them and anoint them with oil for them to be forgiven and saved from sin”. Mark 16:18 is another text used to justify faith healing. It says that “indeed, believers shall lay hands over the sick and they will recover”. Through the sacraments of healing offered by the RCC, the patient who has faith in their healing power can attain physical and spiritual healing. The belief is that it is God who heals. If one is sick and receives the sacrament of healing and he or she is not healed physically but ends up dying, the soul will have received the healing as it prepares to unite with God (CCC:1523). In summary, the biblical texts used by both the RCC and other faith healing ministries to justify faith healing are the same but the understanding and interpretation of these texts differ. Faith healing encourages sole trust in God for all healing without relying on medicine, which is in contradiction with what the hospital, with its western biomedical culture, teaches.

As stated in the introduction to this chapter and in the background of and motivation for this thesis, the exclusion of pastors from the healing ministry of mental patients at Saint John of

¹⁸ <https://www.christianitytoday.com/ct/2000/october23/22.22.html> (In the Document *Dominus Iesus: On the Unicity and Salvific Universality of Jesus Christ and the Church*, Pope Emeritus Benedict XVI, then Cardinal Ratzinger avoided the use of church to refer to all protestant churches. Instead, he mentioned them as ‘some ecclesial communities’.

God Mental Hospital only leads patients or their guardians and relatives to seek the services of these pastors after being discharged from hospital. In most cases, faith healers instruct the patients to stop the medication that they received from the hospital. At this time, patients are assured that they have been healed and they should depend on their faith rather than on medication. This has led to many patients suffering relapse. Given this background and the presentation, discussion and analysis of the policy documents that follow it, the researcher now focuses the discussion on the impact that the exclusion of pastors has on mental patients and the subsequent burden of relapse.

2.8. The Impact of Pastors' Exclusion from the Healing Ministry of a Mental Patient

The biggest impact of the exclusion policy at Saint John of God Mental Hospital lies in the relapse of mental patients. In this section I will discuss the impact that the relapse of clients has on the hospital, relatives and guardians as well as the patients themselves. I am aware that pastors' instruction to stop medication is just one of the many causes of relapse in mentally ill people. As noted by John J. Miller, pregnancy, financial status, medical comorbidities, extended travel abroad and geographical relocation are all leading factors that result in the cessation of medication (2013:32). However, one cannot deny the fact that pastors are systematically excluded from the delivery of mental health care at Saint John of God Mental Hospital and that this has a negative impact on the lives of people suffering from mental illness. Such instances of relapse have cost implications for the hospital and the government, affect the relatives and guardians of the mentally ill through the continued burden of care and in some cases, even lead to the death of patients through suicide owing to the frustration of recurrent sickness (American Psychiatric Association, 2013:149).

Bopp and colleagues assert that "pastors are an important example of 'gateway providers' because they have a very big influence on their flock and shape the physical and social settings for the community as related to health matters" (2013:185). In this regard, pastors are key to many of the decisions that people in the community make. Throughout most of the Christian era, pastors have been among the leading producers of culture and agents of change in the communities where they command the consistent respect and attention of their audience (Poirier, 2006:17). It is in this regard that they are consulted by mental patients and their guardians in their search for healing. Studies have indicated the positive influence that the

pastors have on the health seeking behaviour of their flock (Chilale, et al, 2014:504, Koenig, 2004:1196, Sorsdahl et al., 2010).

2.8.1. Culture as a Factor in the Exclusion of Pastors

While most cultures of the world are religious (Oladipo 1998), Africans are qualified as notoriously so (Mbiti, 1991:1). Religion is not just an experience in Africa but it covers all life situations of many Africans (Oladipo, 1998:201-202). Indeed Africans are people who value community as an aspect of belonging in the pluralistic world where commitments are largely shaped by the extent of this pluralism. While not making a direct reference to relapse and the case of pastors in Africa, but rather an approach to life in general, Louw asks and responds to the question “what is African in Africa” in the following way:

Africa functions as a hermeneutical paradigm indicating a unique approach to life that differs from the analytical approach emanating from western thinking and Hellenism. Africa is an attempt to describe and interpret how different cultures contribute to a better understanding of the dominant features of a mode of living and a philosophy of life; it refers to, among other things, the needs and struggle of people in this continent (2008:147).

When illness is understood as a religious concept in Africa, it shows that damage has been done to the spiritual chain of protection that has angered the ancestors and spiritual powers. This calls for the services of a pastor or a witchdoctor to restore the chain of protection (Louw, 2008:169).

Mentally ill people’s regard for pastors can therefore be understood if approached from Mbiti’s and Louw’s observation of African culture as inclined towards the sacred and the religious. Pastors lead and manage religious congregations which in essence determine the lives of individuals. These congregations draw people into an intimate community, encourage them to worship and provide them with instructions of lasting personal or social significance (Manala, 2010:1). Louw in particular documents the importance of pastors. He argues that, in the community, “the pastor fulfils the role of a networker and a bridge builder in order to change the cause-and-effect approach into a purpose-and-meaning -giving approach” (2008:181). An

individual's environment is shaped by the connectedness of interaction or processes taking place in the community in which they are domiciled (Louw, 2008:171). Healing then does not revolve around an individual patient but is rather concerned with a group – the family, neighbours or larger community (Mpofu, 2011; Hemshorn de Sanches, 2003:72). Both Mpofu's and Hemshorn de Sanches' approaches to healing indicate its communal aspect (Mpofu, 2011; Hemshorn de Sanches, 2003:72). The cultural environment therefore becomes a necessary component to understanding religion, faith and spirituality in Africa (Louw, 2008:151).

Pastors are not only influential members of the community, but they are also the leaders of congregations and listeners and interpreters of community stories (Louw, 2008:185). Louw takes into consideration the patient's "unique cultural and religious milieu in order to show the pastor's importance in performing an interpretative and listening role in the African context" (2008:185). The congregation acts as a hermeneutical community that helps the individual interpret what is happening in their lives. In the case of a mentally ill person, it means that he or she already belongs to this hermeneutical community and already holds a particular religious view. When such a patient is taken to Saint John of God Mental Hospital for treatment, they acquire another culture that involves taking medication as a remedy for their illness. While in the hospital, the patient also learns to interpret their sickness differently. Upon discharge, they return to their community with a new culture that the community is not aware of. Since the pastors were excluded during the time the patient was in the hospital, they are unable to help the patient to re-interpret their medication in relation to their Christianity. Most likely, the meaning given by the pastors will not be in line with the interpretation offered by the hospital. Once pastors are excluded, the risk of presenting a conflicting culture (stopping medication in favour of faith) becomes unavoidable.

Chilale *et al* explain that in the village setup, "anyone comes to advise where and how treatment of the illness has to done" (2017:422). The culture therefore has its own symbols and rituals which it adapts to help the suffering patient. Eventually, this leads to conflict of information. The African social cultural environment has a different hermeneutical understanding of the illness to the western biological understanding held by the hospital. The discontinuity of information that exists between the hospital and the cultural environment is confusing and debilitating to those suffering from mental illness, because their attachment to the pastor is a necessary supplement to the family and a solace if they are lonely. Ae-Ngibise (2010:558) argues that "the African society is a society that mostly believes that witchcraft is a cause of

mental illness”. As such, there is no hope of recovery for a mentally ill person. Their only coping mechanism becomes the pastor who offers religious prayers (Ae-Ngibise *et al.*, 2015:2).

The above understanding of an African cultural spiritual perspective guides this study to show that it is faith healing that influences the healing process of mental patients admitted to Saint John of God Mental Hospital. When patients relapse, the burden is not only on these patients and the caregivers involved, but also on Saint John of God Mental Hospital. The hospital, the community and the state in general incur extra costs in rehabilitating the relapsed patient. Let me now turn the focus of this discussion to the burden of relapse itself.

2.9. The Global Perspectives in Relapse

George A. Awad and Lakshmi N.P Voruganti (2008:149) discuss that the relapse of mental patients brings personal suffering to the patient. There is also the burden of care on relatives through the transfer of responsibility from hospital to the home environment and direct and indirect economic costs on the society. The burden of care is defined as “a psychological state that ensues from the combination of the physical work, emotional and social pressure” (Dillehay and Sandys, 1990 cited in Awad and Voruganti, 2008:152). In a study done in 1995 that looked at the USA’s yearly expenditure on mental health relapse, the researchers reported that the government spends almost \$2 billion every year on the readmission of people suffering from schizophrenia to hospital (Weiden and Olfson, 1995:419). These figures agree with more recent studies in 2010 that assessed the direct cost of relapse and the predictors of relapse in the treatment of schizophrenia in the US as well as a 2017 study that searched multiple databases to come up with the cost of treating relapsed schizophrenics (Ascher-Svanum *et al.*, 2010, Pennington and McCrone, 2017). Through its database search, the study found sixteen (16) related studies that reported on the costs of relapse and also identified a cost associated with hospitalization for relapse in 43 more studies (Pennington and McCrone, 2017:921). In a one year period of study, researchers reported that the costs were made up of “medications (antipsychotics and psychotics), psychiatric hospitalizations, day treatment, emergency services, psychological group therapy, medication management, individual therapy and case management” (Ascher-Svanum *et al.*, 2010:3). Making a comparison between patients who relapsed and those who did not, the study showed that patients who relapsed recorded 3 times higher total annual direct mental health care costs in one year (\$33,187) as compared with those who did not (\$11,771) (Ascher-Svanum *et al.*, 2010:3). Pennington and McCrone (2017:921)

also report similar cost estimates (\$16,000 to \$33,000) for treating relapsed patients over a period of 6-15 months. These studies confirm that relapse inflicts a significant economic burden on patients, their families and the larger society (Weiden and Olfson, 1995:419-420).

In the Malawian scenario, the cost of relapse is alarming in the sense that “the country is very poor, with almost 71% of the population living on less than a dollar a day” (Phiri, 2017:2). As it is the case in other African countries, mental health services are the lowest on the list of priorities and are poorly funded (Okello and Musisi, 2015:249; Khoaseb, 2014:9). Additionally, all medications for treating mental illness are imported from Europe, America and India. Ascher-Svanum *et al* further notes that “although patients who relapsed had a higher hospitalization rate and emergency services costs, they are also the ones who incurred high medication costs and different outpatient services like medication management, day treatment, individual therapy and case management” (2010:4). These findings confirm that patients’ relapse has a huge economic burden on both the hospital and the country.

In summary, the reported costs of different studies demonstrate that the annual mental health costs of patients who relapsed are about 2 to 5 times higher than for those who do not relapse. Relapse then has direct substantial mental health costs implication for the hospital and the family. These costs go beyond the cost of hospitalization to other outpatient services which are also expensive. Weiden and Olfson (1995:421) add that relapse also has an indirect cost which is loss of productivity and premature death. While most of Saint John of God Mental Hospital’s medical bills are paid by the government of Malawi through a service level agreement (SLA), meaning that patients and caregivers are not paying for the services they receive at the hospital, does not mean that they do not suffer the economic burden of mental illness. Similar to the findings of a study in rural Ghana (Ae-Ngibise *et al.*, 2015:6), relatives and patients in Mzuzu have to travel long distances to reach the hospital and guardians have to find accommodation and food within Mzuzu. Guardians also incur extra cost if the patient is on a special diet because the hospital only provides basic meals.

As mentioned earlier, relapse also has negative effects on the patient’s career as he or she spends much of their time in the hospital, leading to many unproductive days taken off from work. If the patient is employed, an employer may decide to terminate their contract on medical grounds leading to unemployment and loss of income on the part of the patient (Girn *et al.*, 2010:74). In the event of such a relapse, “the family of the patients has to restart the process of

care and support to their relative [...] through the provision of information, active listening, training in empathy, therapeutic alliance and diminishing critical attitude to their relative” (Girn *et al.*, 2010:75). These instances of relapse include those caused by faith healing pastors’ injunction to stop medication. Under these circumstances, patients go back to the hospital in a worse state than they were before, leading to frustration and, in some cases, suicide (American Psychiatric Association, 2013:149). Apart from the economic burden, relapse therefore has “a negative influence on the long term outcome of the illness owing to disruption of psychosocial adjustment and the possible development of resistant psychotic indications” (Xiang *et al.*, 2011:1325).

The role of the family and the burden they carry in caring for a mentally ill person has been a focus of many studies across the globe (Sefasi *et al.*, 2008, Awad and Voruganti, 2008, Ae-Ngibise *et al.*, 2015, Baronet, 1999, Mulud and McCarthy, 2017, Kate *et al.*, 2013, Ussher, 2011, Priestley and McPherson, 2016). In a study among the Italian population that looked at the expressed emotion and the burden of care among relatives of people suffering from schizophrenia, researchers report both an objective and a subjective burden of care (Carra’, 2012:1). This report is similar to what Awad and Voruganti (2008:150) report regarding the objective burden of caring for one single person with mental illness and the direct effects it has on the household. Such an objective burden includes the family’s health, finance and daily chores which are affected because of the illness of a family member. The researchers in the above-mentioned Italian study admit that the burden of care is influenced by some cultural factors. The more communitarian the family is, the larger the burden of caring for their relation. This is also true of the population in the north of Malawi who subscribes to the view that “to exist is to co-exist” (Jolley, 2011:10). As stated by the Anglican Archbishop emeritus Desmond Tutu (2008), “*umuntu ngumuntu ngabantu*” (a human being is a human being because of other human beings). This concept, described as *Ubuntu*, resonates with the earlier views of the Kenyan academician, John Mbiti who is famous for saying: “I am because we are and because we are, therefore I am” (1991:141). While *Ubuntu* and the communitarian spirit is not always honoured and practiced where mental illness is concerned, Kenneth Ayuurebobi Ae-Ngibise and others (2015:3) agree that in Ghana and other African countries, “the community and the church is there to provide social support when death and disaster occur or in the presence of a physical illness.”

The only study conducted at Saint John of God Mental Hospital in Malawi that assessed the caregiver's burden in dealing with a schizophrenic had different findings from similar studies done elsewhere. This Malawian study admits that the burden of care on relatives is enormous as their day to day activities in farming is halted when they have to care for someone who is mentally ill for a long period of time (Sefasi *et al.*, 2008:165). However, the view that most Malawians hold regarding the causes of mental illness lessens this burden to some extent. Most Malawians think that bewitchment and drug abuse are the main causes of mental illness, hence there is little hope of healing unless the patient decides to stop drug abuse or the person responsible for bewitchment decides to reverse their evil actions (Sefasi *et al.*, 2008:165). These Malawian findings do not correspond to the results of studies done in Africa (Gureje *et al.*, 2005), in Asia (Lim and Ahn 2003) and in Europe (Roick *et al.*, 2007) which find that more knowledge contributes to the burden of care. Furthermore, the findings show that in Malawi, relatives may not be free to report a subjective burden of care because "sickness is communally shared and care for the sick relative is easily shared among household members" (Sefasi *et al.*, 2008:164). Despite the community spirit among Malawians, women are more likely to suffer the "emotional, psychological, physical and economic impact" as well as "distressing notions of shame, embarrassment, feelings of guilt and self-blame" that accompany taking care of someone suffering from mental illness (Awad and Voruganti 2008). Likewise, in responding to the question of "what is going on?" my experience working at Saint John of God Mental Hospital shows that women suffer both as patients and caregivers.

2.10. Conclusion

This chapter has presented the three relevant policy documents and made observations regarding their implementation and execution at Saint John of God Mental Hospital in Mzuzu. It has shown that the exclusion of pastors from the healing mission at Saint John of God contributes to patients' relapse. The relapse of patients with mental illness is a burden to patients themselves as well as their guardians and the hospital itself. The major problem with the Malawian policy document is that it has not adopted the latest Curia policy document which recommends a sector-focussed approach to policies and allows patients to seek the services of their respective pastors. Furthermore, the Malawian pastoral care policy captures all the essential elements that are contained in the Provincial policy, making the Malawian policy rely on the Western European policy which is more European than African in orientation.

The chapter has discussed the contradictory information that patients receive when their pastor, who is very influential and instrumental in the production and maintenance of a culture, is excluded from the healing ministry at Saint John of God. The chapter explains that many of the patients have opted to stop medication in favour of faith healing prayers when they find themselves in such a quagmire, leading to their relapse. The discussion has shown that relapse is costly to the community and the hospital, disabling to the patient and causes a burden of care to relatives.

While this chapter has discussed the policy document and the impact of its exclusion of pastors from the delivery of mental health care at Saint John of God Mental Hospital, Chapter Three will analyse published literature in order to explore the positive contributions made by pastors to health care delivery at other hospitals. The discussion of pastors' contributions to health care delivery will help this project to propose and recommend practical ways in which to responsibly involve pastors in the healing ministry at Saint John of God Mental Hospital in Mzuzu. As I will show, such recommendations leading to change are in line with what Hans Kung introduces as a paradigm shift in theology, an idea that originates with Thomas Kuhn (Bosch, 1991:183).

CHAPTER THREE

A HISTORICAL EYE: THE CONTRIBUTION MADE BY THE PASTORAL CARE DISCIPLINE IN HOSPITALS

3.1. Introduction

This chapter focuses on the contributions made by pastors to health care delivery in different hospitals. It aims to analyse published research in order to explore these contributions and determine how pastors of other denominations can be involved in the care and mental health healing at Saint John of God Mental Hospital in order to achieve a sustainable healing ministry. The point of focus behind this analysis is to seek information on how other hospitals have responsibly involved pastors in the healing ministry and to use this information to direct the proposals and amendments made in this study. Therefore, Chapter Three is key to the overall outcome of this research project and it engages the normative task (1.9.1.3) of practical theology, as proposed by Richard Osmer, in asking: What ought to be going on? And what are we going to do as a community of Christians in response to the exclusion of pastors from mental health healing? Using Christian theology and ethics, the normative task assesses the situation with the view of reforming it should the need arise.

According to Osmer, the normative task has three dimensions: “theological interpretation, ethical norm and good practice” (2008:152). This chapter applies all the three norms. Pastoral care is a theological discipline, hence in engaging theological interpretation, the focus is on helping mentally ill people through their present episode, situation and context by employing theological concepts (Osmer, 2008:139). The historical development of pastoral care over the years indicates that God has been at work in all the events and he is in solidarity with the people who are sick in the hospital (Osmer, 2008:144). In the case of this study, God is suffering with the mentally ill patients and he is constantly seeking ways to heal them holistically. Mentally ill people fall in the category of marginalised people who have no voice; the poor who are living on the margins and have no say in what happens to them, resulting in what Osmer calls “systematic miscalculation of their needs” (2008:145). Theologically, pastoral care comes in to offer hope and accompaniment to such human beings by reminding them of God’s unfailing promises (promisiotherapy). It is under such circumstances that feminist liberation theology

plays a role in speaking for people who have lost their voices because of their current situation, mental illness.

The interpretation of the normative task on good practice directs this study to construct norms which will guide the responses to and strengthen the learning of the pastoral care practices to be employed at Saint John of God Mental Hospital in Mzuzu. It is in line with the ethical norm that Osmer makes a specific reference to psychiatric hospitals in stating that “[mental] patients should not be treated as objects but as persons worthy of our respect” (2008:131). The biblical image of prophetic discernment that represents the normative task helps in locating ethical principles, guidelines and rules that would speak to people affected by pastors’ exclusion. The contribution made by pastors through pastoral care that this chapter discusses, shows that there is “no one perspective to capture the fullness of truth [...] but [that] many perspectives are needed to understand the complex and multidimensional phenomena” (Osmer, 2008:83). Consequently, pluralistic models of care are needed to appropriately address the conditions of mentally ill people. This understanding resonates with the local beliefs held by the populace which Saint John of God Mental Hospital serves. In their local language, *Tumbuka*, they say that *tuli tuwiri nthuwanthu, kalikekha nkhanthama* which literally translates as “you are human only with another person, otherwise then you are an animal”.

The three policy documents presented and discussed in Chapter Two, the office of the Pastoral Care Coordinator at Saint John of God Mental Hospital, and some other hospitals acknowledge the positive role of the pastoral care function. According to Daniel Louw (2008:83), a human being is an embodied soul and an “ensouled” body. Pastoral care practice views a person as a unit and, as such, all dimensions are taken into consideration in caring interventions. Holistic care concerns itself with the physical as well as non-physical and spiritual components. In this case, a patient needs both physical and spiritual healing. Pastoral care provided mainly by pastors attends to the spiritual healing of the person, recognising their context, identity and human dignity. In the hospital setup, pastoral care is part of the team that brings healing and hope to the sick. Louw argues that in providing pastoral care to the sick, pastoral caregivers must “pay more attention to the hospital environment [...]. In *cura animarum* as *cura vitae* we visit the systematic environment and context of human embeddedness within the dynamics of several life relationships” (2008:192). At different points in time, pastors have been included in healing teams at hospitals in order to provide unique services that the health care personnel cannot. It is from such a standpoint that Louw confirms that pastors are “specialist on empathy,

interpathy, unconditional love, the will of God in terms of suffering and our human quest for meaning and human dignity and engaging in theological reflection” (2008:193).

As far as the healing of patients is concerned, the question then is: Who is in charge? Is it the doctor, the nurses, the minister, the family, or the patients themselves? Louw responds that the patient as a human being is in charge within the social and cultural environment (2008:214). This does not negate the fact that the doctors, nurses, physiotherapists, occupational therapists, psychiatrists, social workers and pastors in the hospital represent the love of God towards the patient. I agree with Louw’s argument (2008:209) and Shepperd and Iliffe (2005) that a hospital is a familiar place to medical personnel but a strange or frightening place to patients. Familiar pastors can mediate the patient’s fear and alienation and for this reason, this chapter focuses on the contribution made by pastors to the health care delivery as part of the team at the hospital.

As noted in Chapter One, pastors are undisputable collaborators because they have a notable influence in their congregations and communities. It is in this respect that they contribute to people’s health in different ways. Central to the Christian message embedded in the gospel is the mandate to heal individuals who are suffering from illness (Bopp et al., 2013:183). As such, pastors have “a strong influence over their organisations and shape the environments of their institutions with regard to health-related matters” (Bopp, et al., 2013:182). For the success of many programs in the community, then, the involvement of pastors becomes indispensable. Brian Saunders (2002:159) refers to pastors’ contribution to the hospital care setting, whether general or specialist, as pastoral care, chaplaincy or pastoral caregiving. Other studies have also indicated that pastors are in the forefront in the provision of mental health and that many ill people either visit them or ask for their services once they suspect an abnormality in their body and psychological system. (Osafo, Agyapong and Asamoah, 2015:326; Oluwabamide and Umoh, 2011:47; Unuhu *et al.*, 2009:24). Saunders (2002:159) refers to the contribution of pastors in the hospital care setting, general or specialist hospital as pastoral care or chaplaincy or pastoral caregiving.

Based on such an acknowledged importance, many hospitals responsibly and effectively include pastors in their healing mission. Numerous studies report on the high value that patients put on these carers of souls in such hospitals (Piderman, et al., 2010; Kernohan *et al.*, 2007; Chattopadhyay, 2007). Apart from attending to patients, chaplains in the Pastoral Care Department also help staff members to cope with their grief in the hospital (Koopsen and

Young, 2009:53). Evidence based research further confirms that pastoral caregivers are a reliable asset to directors of departments in the hospital, especially in the areas of prayer and emotional support for grief and death (Flannelly, Weaver, and Handzo, 2003, Flannelly *et al.*, 2005:19). Christopher Swift (2014:7) affirms that “chaplains [pastors] form an important meeting point between the historic presence of the church in public spaces and secularisation, contemporary spiritual expression and the close engagement with the life-changing effects of illness”. I have to mention that the studies referred to here were not done in Africa, but I assume that the findings are relevant to the current topic of research since people in general have a high regard for spiritual care, especially when they are sick. Emem Obaji Agbiji (2013:255), in her study of Nigerian hospitals, declares and confirms that “pastoral caregivers do not just offer an alternative to healthcare delivery but are complementary healthcare providers and their practices are of recognisable value”.

To fully determine the extent of pastors’ contribution to health care delivery, this chapter briefly presents a general understanding of pastors as part of the care providing team in hospitals and provides a historical background to pastoral care in hospitals. This historical background opens the door to a discussion of the historical shifts in pastoral care. Furthermore, the chapter discusses the types of pastoral care given in hospitals as well as models for pastoral care giving. I will conclude this chapter on the contribution of pastors by focusing on the tasks and roles that they are engaged in at a hospital.

3.2. Pastors as Care Providers

Saint John of God Mental Hospital’s policy documents and the establishment of a Pastoral Care Department acknowledge the importance of pastoral care in the healing of sick people. As such, this case study operates from the assumption that pastoral care already has a space at Saint John of God Mental Hospital and that it manifests in all the Centre’s areas of service delivery. The problem that this study addresses is the contradictory and ambivalent policy that excludes pastors from the healing mission of the mentally ill at Saint John of God Mental Hospital. The practice of exclusion leaves pastoral care services at the hospital in the hands of the Catholic Pastoral Care Coordinator or any other Catholic priest. This is different from the situation in a study done by Agbiji (2013) which investigates the relevance of pastoral caregivers in Nigerian Hospitals. The aim of this chapter is not to reiterate the importance of pastoral care services to people who are sick and suffering, but rather to articulate the contributions that the field and

its professionals have made in the healthcare context. In order to do so, this study aligns itself with the definition of a pastoral caregiver that Swift presents. He defines chaplains as

[r]epresentatives of their faith communities, which require them to live out the commitment of those communities to the wider world, in this case in a healthcare context. They must therefore be learned in the ways of the faith group and knowledgeable about the basis for its decisions and guidance. In this role, Chaplains are accountable to the faith group for embodying its ethos and teaching appropriately. A regular checking-back and refreshment of this representative is necessary (Swift, 2014:156).

Traditionally, chaplains as clergy and religious leaders, are sent and mandated by their own faith group “to take care of the spiritual needs of the patients and staff in the hospital” (Swift, 2014:155). Their major role as pastors in the hospital setting is to provide pastoral care. Pastors show their unique contribution to healthcare only when they remain within the domains of their role and function (Agbiji, 2013:206). In the same vein, Christo Thesnaar argues that “[pastoral caregivers] need to be well grounded in their identity” (2010:268). The identity will assist the pastoral caregiver to operate within the boundaries of the profession.

Generally, pain and suffering has evoked questions regarding the meaning of life and the position of God. Louw’s book (2000:2) summarises these questions as: Why God? (cause and explanation); How God? (mode and identification); Where God and what? (polarization and the will of God); When God? (transformation and overcoming); For what purpose? (the human quest for meaning). People turn to religion and spirituality to seek solutions. Pastoral caregivers or a chaplains becomes relevant when they help people gain a good hermeneutical understanding of their present situation in line with the God images that they have. Pastoral caregivers and chaplains includes all those who are motivated and directed to carry out such functions in their community of faith, whether or not they are ordained (Benner, 1998:23-25; Lartey, 2003:22; Louw, 2004:21; Calvert, 2009:267; Agbiji, 2013:130). Pastors visit the sick, listen to people who do not have anyone else, do counselling and preach the word. Agbiji (2013:166, 183) adds fostering dialogue, wholeness and hope in people who are weary and suffering as the role of pastors. How did the discipline of pastoral care come to exist?

3.3. Brief Historical Background of the Discipline of Pastoral Care

Charles Gerkin (1997:11), a seasoned pastoral care provider, academician and teacher, shows that pastoral care is an old discipline that has been shaped by many people and reaches back to the memories of the first Christian community. He dedicates the first part of his book, *“Introduction to Pastoral Care”*, to discussing the origins of pastoral care. This is in line with the African view that pastoral care has always existed in Africa through family settings where friends, peers and elders have offered words of wisdom to people in despair (Ghunney, 1993:93). From the biblical times to the present times, pastoral care always responds to people’s experiences and always adapts to the changing situations of the people and the world (Gerkin, 1997:21). Gerkin further argues that during biblical times, pastoral care adopted a biblical model of care where caregivers were known as priests, pastors, wise people and good shepherds. Christianity has therefore grown and spread its forms of pastoral care. Thus, some form of pastoral care has existed during the periods of the primitive church, the persecuted church and the imperial church which existed after the reign of Emperor Constantine, sacramentalism in the middle ages, reformation, enlightenment, the age of volunteerism and religious privatism. Sigmund Freud also influenced the discipline of pastoral care in the 20th century through psychoanalysis (Gerkin, 1997:53). Pastoral care owes its interdisciplinary beginning to Anton Boison. Boison was an American pastor in the US, a mental patient and the founder of Clinical Pastoral Care Education (CPE) in 1936 (Gerkin, 1997:60, McClure, 2012:272). Boison is a “very important transitional figure in the history of pastoral care, a social advocate for the proper treatment of mentally ill people and the originator of the empirical study of pastoral care which made a connection between sin and salvation” (Gerkin, 1997:62). This chronology shows that pastoral care is an old discipline and many people have influenced its practice.

Louw (2011) avoids a chronological history of pastoral care and reports instead on broad approaches regarding the development of pastoral care in the Christian tradition. He documents five approaches (2011:159):

- (1) *kerygmatic approach*, in the reformed tradition, with the emphasis on sin, confession and proclamation; (2) *sacramental approach*, in the Roman Catholic tradition, with the emphasis on the sacrament of confession and the liturgy of intercession; (3) emphasis is on deliverance and exorcism within more *charismatic* approaches; (4) the influence of Western psychology; and (5) the bipolar model,

which emphasizes the interplay between the spiritual dimension of care (the human quest for meaning) and the human/personal/existential dimension of care (need-satisfaction and the empirical aspect).

Louw admits that these approaches “have to be linked to African epistemology and cosmology in order to understand the setting in which African people live and operate” (2011:159). In this regard, he encourages pastors to combine care and counselling with issues of liberation and empowerment that speak to the many marginalised people in African society (Louw, 2011:159). Liberation and empowerment counselling is also important to the population of this study who are marginalised because of their mental illness (Cobb, 2005:58). Unlike in the individualised western society where the discipline first developed, Africa has a communitarian spirit in need of social, political and public healing (Louw, 2011:159). Pastoral caregivers should focus on people’s life events and their interrelatedness as part of a holistic and integrated understanding aimed at healing all broken relationships.

Swift (2014:9) argues that “for more than a thousand years now, part of the normal life [of the church] has been assigning clergy to offer their work in hospitals.” Further, he states that the clergy’s main duty in the early days, before reformation, was to offer prayers and promise the economy of salvation to individuals before they died (Faye, 1998:91 cited in Swift, 2014:9). The hospital and the church existed as one, both in architectural design and with regard to their duties. The doctor (the physician of the body) was supposed to instruct the patient to consult the priest (the physician of the soul) to remove the sin that may be causing the illness so that the person can respond well to physical treatment (Swift, 2014:10). Swift (2014:9-27) shows the close connection that existed between the church and the hospital’s healing mission up to the present times.

The discipline of pastoral care has been grounded and developed in the western and Judeo-Christian world (Gilliat-Ray, 2010:145, Johnson, 2001:40-41). For a very long period of time, the office of chaplaincy in hospitals was occupied by men. It is not the mandate of this study to look at the contributions made by practitioners of other faiths to health care delivery, but rather to limit itself to the contributions of Christian pastors. These are pastors conducting their duties in a heterogeneous (intercultural, interfaith, intersexual, etc.) hospital environment (Swift, 2014:13). The historical overview of pastoral care provision in hospitals indicates that the discipline has undergone changes throughout its history. It shows that pastoral care is

dynamic and constantly on the move to respond to the emerging and unique situations that people find themselves in. In the same vein, Lartey states that “[p]astoral care is dependent upon the cultures, reigning philosophies and psychologies of the periods in which it is practiced” (Lartey, 2004:2004). I now turn my focus to explore the shifts that pastoral care has undergone.

3.4. Paradigm Shifts in Pastoral Care

There are many paradigms employed by different disciplines like pastoral theology and psychology. In order to safeguard the identity of pastoral theology, Louw argues that its paradigms employ the perspective of faith which makes it different from other science disciplines (1998:100). He further points out that “the most appropriate paradigm for doing theology is a hermeneutics that allows explanation, speech, translation, communication, interpretation and understanding” (1998:102). The focus of hermeneutics is on the pre-text, text and context (1998:102). Louw emphasizes that any theology and practice of pastoral care should undergo an important paradigm shift (1998:120).

A paradigm is a “model that both generates and governs creative thinking as well as shapes and defines the parameters and content of a specific field” (Kimble, 1994:80). Louw (1998:13) explains that a paradigm is a “dynamic concept which is subject to shifts as informed by cultural, spiritual, political, economic and global changes for the purpose of making a particular concept meaningful to the context in which it serves.” This research study aligns itself with Louw’s definition of a paradigm. It is understood that cultural, spiritual, political, economic and global events affect the definition, understanding and practice of pastoral care as a theological enterprise (Ramsay, 2004:7). Pastoral care cannot remain oblivious to the changes happening around the world as it deals with the real contextual situations of people who go through new realities in both their personal and professional lives (Kimble, 1994:81). Most people who are influenced by the African cultural context exist and live in families and communities with deep cultural and natural settings. The collective and distinct being that exists among people with African origins defines who they are in their togetherness. As noted earlier, in the discussion of the history of pastoral care, pastoral care has been defined and redefined throughout the long history of Christianity to attain its identity. Agbiji (2013:135) argues that “identity formation is the total sum of the continuous construction and reconstruction of the concepts and theory inherent in a belief system and its values as driven

by the discipline's social context". While the general understanding of the paradigm is that it changes, Bosch (1991:186) issues a warning that paradigms in theology do not operate like in natural sciences where the old are completely replaced by the new. Rather the old and forgotten paradigms can still be relevant, revived and reused.

John Patton, a pastoral care theologian and a counsellor, presents a simplified version of the three paradigm shifts which are used to interpret the historical changes in pastoral care, namely classical, clinical and communal contextual paradigms. While the three paradigms do not originate with Patton, he effectively employs them to summarise the complex changes that have taken place in pastoral care. These same paradigms, which Patton borrows from other pastoral theologians like Thomas Oden (1984), have been taken up and used in recent times to discuss changes in the discipline (Ramsay, 2004:1-44, McClure, 2012:275-76). While Patton puts a lot of emphasis on the third paradigm, communal contextual, he too calls for a review of pastoral care in terms of its context, person and message. He calls upon all caregivers to "remember who they are as God's people and to hear and remember those to whom they minister" (Patton, 1993:5). Before other faith groups started having an influence on the discipline of pastoral care, Christian principles dominated and saturated it. Next, Patton's three paradigms will be discussed chronologically, beginning with the classical paradigm which is presumed to be the oldest way of pastoral care giving.

3.4.1. The Classical Paradigm

The classical paradigm is the oldest and most practiced of the three paradigms. In reviewing the book, *Pastoral Care in Context: An Introduction to Pastoral Care*, Val H. Hennig (1995) says that the classical method is most familiar to ministers who have been in a parish setup for some time. He further says that "this method is good and has to be preserved so that it can be interpreted in today's world" (1995:166). Basically, this paradigm involves preaching the word of God to people and assuring them that He still cares for them. The classical paradigm is believed to have existed from the start of Christianity up to the 20th century (Oden 1984). However, when psychology began to have an impact on the pastoral care ministry, the classical paradigm became obsolete (Patton, 1993:4-5). During this period, Christianity was a dominant faith, hence pastoral care was being practiced in an environment with almost the same people professing the same faith. Pastoral care in the classical paradigm was congregationally based. The hospitals, as centres of evangelisation, placed emphasis on bringing lost souls back to God.

Sin was seen as the causative agent of all human problems and illnesses (McClure, 2012:273). Swift stresses that at the time, physicians of the body were sending their patients first to physicians of the soul for them to confess their sins in order to accelerate their physical healing (2014:10). The pastoral care practice among people professing the same faith also agrees with Gerkin's earlier assertion (1997:31) that repentance and confession within the community of faith were important models for pastoral care. Gerkin further argues that "pastoral care in the classical paradigm communicated the care of God to his people through ritual practices, preaching and counselling" (1997:24). Andrew Purves' (2004:162) assertion that "the pastoral care practice cannot be concerned with anything other than the proclamation of the gospel, the forgiveness of sins and the sanctification of man", is in line with the views of many of these scholars.

McClure stipulates that the main message given to people at this time was for them to repent and confess their sins in search of forgiveness (2012:271). Through preaching and the administration of sacraments, pastoral caregivers reconciled sinners to God. As such, it was logical that the work of pastoral caregiving in the classical paradigm was reserved for ordained Christian ministers who had formal training in a seminary (Townsend 2009 cited in Agbiji, 2013:137-138). Their message was that Jesus Christ is the living word of God who came to take sins away. The classical paradigm's emphasis was therefore on theological content, scripture and the proclamation (kerygma) of the biblical message. The church fathers were the main pastoral theologians in the classical paradigm. It is on such a basis that this classical paradigm of pastoral was more relevant in and utilized by the Roman Catholic Church.

The classical paradigm could, however, not function properly in the event that there were only a few pastors. Oden (1984) states that the classical paradigm's definitive uniqueness lies in its emphasis on scriptures and prayer. In addition to being sick, the patient was not allowed to speak out or voice their concerns. The church, through the clergy possessed the truth, therefore, patients were systematically marginalised. While the content of preaching, repentance, evangelisation, forgiveness of sins and reconciliation may have made a lot of sense within the congregation, Agbiji (2013:139) questions the effectiveness and appropriateness of such practices in a hospital? The shift from the congregation to a hospital setting where there is a diversity of faith among people, necessitates a revision of the practice. Hospitals are communities defined by illness and injury not faith or culture (Cobb, 2005:79). Louw (1998:26) is against an emphasis on sin and repentance when dealing with illness because such stress may

increase the patient's existing problems. Berinyuu (1988:3) and Louw (1998:26) agree that a theology that emphasizes sin falls victim to isolation, blaming, discrimination and stigmatization and, in so doing, challenges the very African concept of *Ubuntu*.

A pastoral care practice that puts an emphasis on sin and repentance brings with it more challenges to believers and patients. The mercy of God is questioned if healing has not taken place after the patient confesses their sins. Khoaseb's (2014) research participants still struggled with illness despite being prayed for. In such circumstances, patients wonder why God does not show mercy and forgiveness to his people after confessions. The issue of sin may additionally bring even more challenges in the context of a mental health hospital where most patients do not have the proper reasoning abilities to know how to confess their sins. Another shortcoming of the classical paradigm that Louw identifies is that it ignores the existential feelings of patients through its method of advising and directing people (1998:26). According to Cooper-White (2012:24), meaningful pastoral care to patients recognizes their experience of suffering. In this regard, a good theology must be relevant to healing and liberation in order to shape the patients' and community's responses to illness and suffering. As such, Townsend's remark (2009:9) that pastoral care should have sound theologies in order for it to support ministry in the public arena, is useful to this study. Jay E. Adam (1976) criticized the discipline of psychology and psychiatry as having a bad influence on the theory and practice of pastoral care. While the classical paradigm served as model for pastoral care delivery in the early days of Christianity up to the 20th century, it showed some weaknesses. These shortcomings led to the emergence of the clinical pastoral paradigm meant to solve the problems which the classical pastoral paradigm brought.

3.4.2. The Clinical Paradigm

The clinical paradigm was developed in the clinical (hospital) setup in the mid of 20th century (Ramsay, 2004:26, Patton, 1993:4). Many scholars view the clinical pastoral care paradigm as an updated version of the classical paradigm (Miller-McLemore, 2004, Marshal, 2004). Caregiving in the clinical paradigm operates on the assumption that for there to be good care, there must be good relationships among people. The philosopher, Martin Heidegger uses good care as a definition of being human (cited in Patton, 1993:17). In contrast with the classical paradigm insistence on the word, the clinical paradigm is client-centred in the sense that people and their relationships are given priority over care (McClure, 2012:273). This approach does

not relegate the importance of the word but, as Louw (1998:27) puts it, good care depends on the interpersonal relationships nurtured by good communication skills. Though the clinical pastoral care paradigm was received with hostility in university learning curriculum (Kimble, 1994:80), Thornton takes it as a good paradigm because it begins with a concern with what a minister must do and goes on to question what a minister must know, then what a minister must say before progressing to the question of what a minister must be (cited in Patton, 1993:4). The clinical paradigm is distinct because of its emphasis on the need for a minister to be trained and acquire an area of specialisation in order to respond well to the suffering of people in hospital. Similar to the earlier paradigm, the clinical paradigm began with ordination and ecclesiastical connection as a prerequisite to be trained and to specialise in clinical pastoral care education (CPE). The changes in the context of pastoral care practice also necessitated changes in who should be trained and attain specialisation in CPE.

Specialisation and the need for accreditation removed the pastoral care discipline from the confines of the church with its emphasis on ordination. This development saw a mixture of the clergy and lay people getting trained in CPE, hence the ordination emphasised in the classical paradigm was not seen as necessary to becoming a pastoral caregiver in the clinical paradigm (Carson, 2010:340-341). While Thesnaar (2010:267) refers to such a situation as an identity crisis for the pastoral carer, Townsend (2004:124) expresses fear that disregarding ordination may compromise the accountability and behavioural practice of the profession. McClure (2012:272) is in agreement with Townsend and argues that playing down ordination as part of the identity of the pastoral carer is tantamount to the secularisation of the profession. Further criticism of the clinical pastoral care paradigm comes from Purves (2004:xix) who states that the paradigm “has been framed by interrelated ethical, symbolic and functional dimensions which in the end suppresses the Christian doctrine of God”. He further observes that pastoral care under this dimension “is more concerned with meaning than with the truth” (2004:xix). Miller-McLemore (2007:27) views all the criticism laid against the clinical paradigm as a sign that pastoral care practice and theology is poorly understood. In refuting this negative view of the specialisation attached to pastoral care, she stipulates that pastoral theology is a performative discipline concerned with realistic transformative action and not right belief (Miller-McLemore, 2007:29). In voicing these views, she agrees with Rassool (2000:1481) who defends the discipline of pastoral care from an Islamic point of view in his argument that at the practice level, pastoral care is related to knowledge, skills and resources.

The clinical pastoral care paradigm approaches pastoral care from an interdisciplinary and interfaith standpoint with the aim of achieving good practice (Agbiji, 2013:144). This approach widens the horizon to include people of other faiths but also the women who may have been excluded by the demand for ordination. This is a huge step in moving away from the classical model which is exclusive and patriarchal. It further showcases the development of the pastoral care discipline owing to its insistence on training and engaging with other disciplines like psychology and health. Townsend (2004:121) confirms that pastoral care which engages an interdisciplinary approach flourishes and, in the process, renders the classical paradigm obsolete. Osmer (2008:163) similarly advocates that pastoral care engages such an interdisciplinary approach .

Boison, a pastor, psychiatric patient and the founder of CPE, influenced the clinical paradigm to adopt an interdisciplinary approach (McClure, 2012:272, Gerkin, 1997:61). His thinking was that CPE should approach problems affecting humanity in real practical life situations rather than in books and traditions (Jones, 2006:128). CPE learners gain the skills of the profession as well as knowledge of themselves and their work through clinical supervision by a qualified supervisor (O' Connor, 1998:7-8). The distinctive feature in the leaning process of CPE is therefore supervision. Though the clinical pastoral paradigm successfully addressed the weaknesses of the classical model, it is not exempt from criticism. Since the paradigm is as a result of human construction, Osmer argues that it is imperfect (2008:103). Many theologians agree that the biggest weakness of the clinical pastoral care paradigm is "its individualistic focus which neglects the group and community care" (Gerkin, 1997:65). This weakness led the clinical pastoral care practice to move from an individual focus to a concern with the community, hence the birth of the third, communal contextual paradigm.

3.4.3. The Communal Contextual Paradigm

This paradigm emerged as a result of the theology of ecumenism propagated by the second Vatican Council and the Consultation on Church Union (CCU) and was furthered by the liberation movement related to development, race and gender (Patton, 1993:4). This paradigm takes the caring community beyond the clergy to include the laity and gives special consideration to the contexts of both the caregiver and care receiver. This paradigm focusses on the entire community context in which patients find themselves as they seek to be cared for by their relatives and the medical personnel in the healthcare institution. In this paradigm, care

is taken to be a ministry of the faith community, aimed at reminding all scattered and marginalised people that God remembers them (Patton, 1993:5; Cobb, 2005:23-24). The communal contextual paradigm combines both the classical and clinical paradigm in order to respond to the current situations faced by the discipline of care in an environment saturated by diverse beliefs and faiths. Patton argues that the communal contextual model is, at the same time, both old and new. He states that “it is old in that it is based on the biblical tradition’s presentation of a God who cares and who forms those who have been claimed as God’s own into a community” (Patton, 1993:5). The model is new in that “it emphasises the caring community and the various contexts for care rather than focusing on pastoral care as the work of the ordained pastor” (Patton, 1993:5).

While Patton, who is the central figure writing on these three pastoral care paradigms, describes this last paradigm as communal contextual, Lartey (2003) calls it the intercultural counselling approach. Lartey uses intercultural to “capture the complex nature of the interaction between people who have been influenced by different cultures, social context, origins and who themselves are often enigmatic composites of various strands of ethnicity, race, geography, culture and socio-economic settings” (2003:13). Lartey argues that “all counselling is cross-cultural since all humans differ in their cultural background, lifestyle, colour, sexual orientation and values” (2003:13-14). This study combines Patton’s and Lartey’s approaches to come up with the communal contextual and intercultural pastoral care paradigm. From Lartey’s discussion of intercultural counselling and Patton’s discussion of the communal contextual paradigm, I understand the value of context, of dealing with multiple perspectives and of authentic participation in the ministry of caring. In noting the importance of context, this paradigm is in agreement with the recommendations made in the Curia policy document that I presented and discussed in Chapter Two as well as the teaching of the RCC on inculturation that I discussed in Chapter One.

3.4.4. The Communal Contextual and Intercultural Pastoral Care Paradigm

The communal contextual and intercultural paradigm is a combination of the models suggested by Patton and Lartey respectively. Vivian V. Msomi (2008:206) argues that the discipline of pastoral care should take cultural, social, religious and political factors seriously as it assists people who are in need of care. Seen from this angle, the discipline of pastoral care recognises, considers and incorporates the contexts of the people it is ministering to. This corresponds to

Berinyuu's assertion that "Africans should not just rely wholesomely on western type of healing and care but should be helped to make use of strength found in within their group, personality and culture" (1988:10). Apart from multiple cultures, the intercultural paradigm focuses on pastoral care that also goes beyond the horizons of an individual's faith community. As caregivers offer their time and skills to care for suffering people in the community, hospital and church, they meet with people from different contexts. These people have different theological standpoints, races, genders, economic classes and sexual orientations, all of which caregivers need to understand and respond to. Through contextual analysis, Larney says that caregivers should understand different worldviews and practices so that pastoral care can become a channel whereby people can be assisted in caring for one another as well (2006:46). As such, the person and his/her context is more important in the communal contextual and intercultural paradigm than in other paradigms. Larney further states that "contextual analysis is a way of knowing the mind of God through the different contexts and conditions of human experiences" (2006:50). The emphasis on the community shows that pastoral care is not exclusively the task of religious leaders but that it can be done by an entire community of people. It is in this regard that Agbiji (2013:149) acknowledges the special and unequal roles played by family members, friends, neighbours, lay caregivers and workmates in delivering pastoral care services.

Pastoral care's widening horizon means that the discipline has to meet and confront ethical issues regarding gender, justice, violence, abuse, racism and other forms of inequality and therefore demands a working relationship with health care and other helping professions. The contextual paradigm also employs feminism theological thinking, which aims to fight patriarchal hierarchy, impositions and cultural indifferences as well as violence against the marginalised members of society, in order to bring equality among men and women as they search for new approaches to the current allocations of power and privilege (Gerkin, 1997:65). Scholars affirm that feminist theology, or what others refer to as womanist theology, has a big impact on pastoral care theories and practice (Van Arkel, 2000; Gorsuch, 2001). Van Arkel argues that it is the feminist movement that has made pastoral care aware of the wider context of care (2000:147). In agreement with Van Arkel, Agbiji makes a strong statement regarding the influence of the feminist movement, arguing that "the work of feminist and womanist theology and theologians in the current paradigm is bearing fruit, as is evidenced in the increasing attention of the subjugated and marginalised as authentic and important sources of knowledge" (2013:149). These "voices from the margins", as they are sometimes termed,

“have generated a pastoral perspective that is sensitive to communal being and experience” (Agbiji, 2013:149). The communal contextual and intercultural paradigm therefore makes pastoral caregivers pay closer attention to context so that they can competently interpret the experiences and specific contexts of care receivers (Lartey, 2006:42-50). As the main advocate for the intercultural paradigm, Lartey proposes that it is the best way of providing pastoral care because of the cultural diversity within and among communities, especially in Africa. He sees this diversity as a result of globalisation, internationalisation and indigenisation (2006:43-47).

The development or changes discussed in this section indicates that the pastoral care discipline responds to each situation at a given time in history with regard to its context. Cobb argues that “understanding context is a key task for any chaplain who is concerned about good practice” (2005:xii). The discipline started in a particular faith group, but over time, it has developed through its interdisciplinary engagement and even extended to other faiths (Osmer, 2008:163; Townsend, 2004:131; Marshal, 2004:146). Mowat notes the progressive nature of the discipline in arguing that “it has moved from religion-focused model to a multi-faith, spiritual approach” (cited in Orton, 2008:116). The question that remains is: Which is the appropriate paradigm for pastoral care practice today? Or how should pastoral care apply these paradigms to achieve best practice, especially at Saint John of God Mental Hospital? The hermeneutical approach that is suggested by different authors, including Louw (2012) and Osmer (2008), seems to incorporate several useful elements. Osmer, for example, states that any good ministry is concerned with solving and fixing problems, but it is a ministry that has to be ventured into and explored (2008:x). Osmer’s thinking gives room to see the situation, explore it and interpret it so that there is a proper intervention. Additionally, the explorative nature and the flexibility of a hermeneutical approach may best accommodate the African understanding of healing that I discussed in Chapter One. I will return to a hermeneutical approach later on in this chapter (3.8), but first, I want to discuss the categories of people who provide care in the hospital. My discussion of the historical development of pastoral care, the practice of pastoral care currently available at Saint John of God Mental Hospital and the types of pastoral care as well as caregivers at the hospital, provides a basis for a discussion of the proposed hermeneutical approach. Let me begin with the pastoral care providers.

3.5. The Pastoral Care Providers at the Hospital

Many people visit a patient admitted to hospital. These people visit to offer different kinds of support, including spiritual support. Twenty years ago, Kirkwood identified four types of pastoral carers: “the hospital visitor, the lay pastoral worker/[volunteer], a visiting member of the clergy and the chaplain” (Kirkwood, 1995:xi-xiv). At Saint John of God Mental Hospital, pastoral care provision is an important asset with regard to the recovery process of patients. Unlike in other general hospitals where family members would take turns to stay with the patient in order to provide for physical, psychological, spiritual and emotional needs, patients at Saint John of God Mental Hospital have no resident guardians. Family members, friends, neighbours and church members are allocated specific times during the day when they can visit patients. Owing to the discrimination and burden of care that is attached to mental illness, some patients have no one who visits them during the whole period of their stay in the hospital (Doron, et al., 2009:79). In such circumstances, the pastoral caregiver offers the services that could be delivered by relatives and friends. It is very rare for patients or their relatives to choose who should provide spiritual care to them when they are in dire need (Schneider-Harpprecht, 2003:96). Furthermore, even if church members visit the patient in the hospital, the policy does not allow them to conduct any prayers unless the patient requested for such a service through the office of the Pastoral Care Coordinator. It is from such a background that I want to discuss the different categories of people who generally provide care at hospitals with a view of using the discussion to relate to Saint John of God Mental Hospital’s pastoral care practice

3.5.1. Hospital Visitors

Hospital visitors are care providers who possess no special skills as far as pastoral care giving is involved. Moved by their own conviction and sense of solidarity, they go to the hospital to provide emotional and spiritual support to a patient who may be a relative, a neighbour, a friend or a church member. Hospital visitors have access to the patient during specific visiting hours as decided by the hospital administration. In a general hospital setup, such hospital visitors have open access to the patient if they happen to be the sick person’s primary caretakers. Hospital visitors have specific person(s) that they visit in the hospital and these specific patient(s) becomes the sole recipients of the pastoral care they offer. Hospital visitors do not need any salary or stipend to provide spiritual and emotional support to these patients. Although they are, for the most part, not ordained and have not attained any training in the caring

profession, they are still caregivers to people who are grappling with illness (Bickle, 2003:4). Next, I consider another group of caregivers that visit patients in a similar capacity, but represent a certain faith or church denomination.

3.5.2. Volunteers/Non-Ordained Pastoral Caregivers

Volunteers or non-ordained pastoral caregivers visit patients at the hospital as a representative of a certain denomination. They are motivated by the fact that the patient shares their religious beliefs and feel obliged to visit the hospital on behalf of their faith community. Unlike the hospital visitor, volunteers are usually part of a group. They may have some basic orientation to hospital visitation offered by their pastor because they take hospital ministry as an apostolate at their church. Although such people may therefore have some basic training in how to conduct hospital visitation, they do not possess any special skills related to the practice of pastoral care in the hospital (Kirkwood, 1995:xiii). They have specific days of the week when they conduct their visits and are usually recognised by hospital staff as a group that offers spiritual care to members of their church on scheduled visits. Because of their regular visits, such a group may have more privileges in carrying out their duties and they may be allowed to visit outside of the prescribed hours. Hospital staff also usually call upon such groups to offer prayers to patients when such services are called for (Kirkwood, 1995:xiii). Similar to the general hospitals visitors, volunteers also focus their caregiving on members of their own denomination, leaving out anyone who does not belong to their faith group.

3.5.3. Ordained Visiting Members of the Clergy

While the nature of their visits is similar to those of non-ordained volunteers, members of the clergy differ from volunteers and general visitors because of their training at a theological seminary. While some may be full time serving pastors, others are part time pastors in different denominations or they are co-opted non-medical members of the hospital. They are more skilled than the two groups of caregivers above because of their exposure to theological education during their training as pastors. These pastors visit the hospital regularly and are recognised by the hospital staff who may call upon them for sacraments and special prayers as requested by patients or their relatives (Kirkwood, 1995:xiii). Because of their status as known spiritual care providers, they manage to visit the hospital outside the normal visiting hours, much like volunteers (Orton, 2008:115). Visiting members of the clergy also have a tendency

to limit their care to members of their own denominations, leaving out those who cannot reach their own pastors or those who have no attachment to a specific denomination. This seems to be the main model for pastoral care provision in Malawi, where members of the clergy surrounding a certain hospital feel obliged to offer pastoral care to members of their church who are receiving care at that hospital. Another shortcoming of visiting members of the clergy is that they are not part of the hospital's clinical team (Orton, 2008:117) This positioning limits their potential for collaboration owing to a lack of professional training (Johnson 2003). This is reported in the research of Lindsay B. Carey and Jacob Cohen (2009:364) who argue that "chaplains who never did some form of tertiary education and CPE could not manage to provide holistic care because their access to patients and staff members were restricted." Orton (2008:115) similarly notes that chaplains without training are not efficient, effective or evidence based in their practice, contrary to the wishes of the patients they care for. It is such a recognised need for pastoral care providers that have special training so that they can be part of a clinical team that provides holistic care that led to the emergence of professional pastoral care providers.

3.5.4. Professional Providers – Certified Chaplains

Professional pastoral care providers are people (lay or ordained) who, in addition to having gained clinical experience, have had training in theology, religious studies, psychology, social sciences, bioethics and the medical humanities in order for them to understand the patients' spirituality and provide appropriate spiritual care (Piderman, et al., 2010:1002). Their training enables them to be part of the hospital's clinical team, complementing the work of other health care professionals. The knowledge they gain gives them a basic understanding of clinical sciences in terms of medical terminology, patient management, common types of therapy, diagnostic investigations and major disease processes (Cobb, 2005:26). The social, religious, cultural and political contexts within which these professional pastoral care providers operate determines the conceptualisation of their role (Kofinas, 2006:671). In most healthcare institutions, as it is the case in Europe, their specialised training enables them to offer spiritual care as part of the hospital's multidimensional team ('Standards for healthcare chaplaincy in Europe', 2006:682). Cobb indicates that their professional roles hold chaplains, as part of allied health professionals, accountable to their respective faith groups and not the Health

Professional Council (HPC)¹⁹ (2005:13-16). Professional chaplains are mostly employed on a fulltime basis by health institutions and coordinate all activities related to patients' spiritual care (Orton, 2008:115; Cobb, 2005:9).

Major emphasis is placed on professional pastoral care providers attending higher level institutions of learning in order for them to have specialised knowledge, be familiar with scientific methods that will enable them to enlarge the body of knowledge, follow the code of ethics, show commitment and offer good services to the general public (Smeets, Gribnau and van der Ven, 2011:80). People who are trained in a specialised field act with confidence and earn the respect and trust of the people they are serving. Unlike hospital visitors, volunteers and the visiting clergy, professional pastoral care providers have an advantage in the hospital since they are formerly consulted by doctors and nurses regarding the spiritual needs of patients. They work full time in the hospital, hence they earn a salary, are not limited to visiting hours and offer ecumenical services to all patients regardless of their religious affiliation.

3.6. The Current Pastoral Care Practice at Saint John of God Mental Hospital

This study will now consider the current situation at Saint John of God Mental Hospital in relation to the above discussion of the different types of pastoral care providers that work within health care facilities. In doing so, it aims to propose a pastoral care model or approach that can best serve the patients' needs. As highlighted in Chapter Two, the current policy that excludes pastors from the provision of pastoral care has had adverse effects.

Saint John of God Mental Hospital has all the four types of pastoral care providers discussed above. There are church groups (volunteers) that come to the hospital periodically to address some of the patients' basic needs. Gifts like soap, sugar, fruits and bread are presented to the patients during a short prayer service. There are also general visitors who cheer the patients in the hospital. There is also a Catholic priest (visiting clergy) who comes every month to celebrate Holy Mass with staff members and some patients. Thirdly, there is a Pastoral Care Coordinator (a member of the RCC) who is professionally trained in theology and CPE. The

¹⁹ HPC is a regulatory body in Britain that is responsible for the state registration, standard of education and training, conduct and performance of allied health professionals.

Pastoral Care Coordinator is responsible for all the spiritual needs of the patients and their relatives as well as staff members. He or she is a member of a multidimensional team and works on a fulltime basis. Unlike in Europe (‘Standards for healthcare chaplaincy in Europe’, 2006:682) where a professional pastoral care provider has to be accredited, there is no accreditation body for chaplains in Malawi. Despite being a member of the RCC, the Pastoral Care Coordinator is not answerable to the leaders of the Catholic Church at the parish or the diocese, rather he or she is held accountable by the program manager and the director of Saint John of God Services. The question now is: Which type of pastoral care provider is suitable to Saint John of God Mental Hospital? In a study that was interested in pastoral care in Nigerian Hospitals, Agbiji (2013:226) groups the four types of pastoral care given in hospitals into two major models: parochial and professional. Her grouping reflects on an earlier study which indicated that the two, parochial and professional model, are true version of chaplaincy in the hospital (Engelhardt, 2003:145). In view of finding a proper model for Saint John of God Mental Hospital in Malawi, I next discuss these two models in line with pastoral care paradigms and the four types of pastoral care providers in hospitals.

3.7. Types of Pastoral Care Provision in the Hospitals

The main focus of this section is to discuss the two proposed models of pastoral care given in the hospital setting. This discussion bears in mind two things: firstly, the three paradigms of pastoral care provision in hospitals (the classical, clinical and communal contextual and intercultural) and secondly, the four types of pastoral care provision in hospitals (the hospital visitors, volunteers/non-ordained pastoral caregivers, visiting members of the clergy and the professional providers/chaplains). I will begin with the parochial model.

3.7.1. The Parochial Model

As discussed above, this is an old and traditional model in which pastoral care in hospitals is provided by “people who have not had any basic training in the caring profession” but instead operate on a voluntary basis (Orton 2008). This model focuses on the provision of pastoral care to patients in the hospital who are affiliated to the denomination of the care provider. The parochial model dwells much on the preaching of the word of God, conducting prayers and using Christian symbols and rituals. In this model, pastoral care providers adopt a harsh and exclusive stance that advocates a specific faith, claiming that it is the only true form of religious

expression (Schmidt and Egler, 1998:239; Engelhardt, 2003:148). Schmidt and Egler (1998) further argue that the thinking behind such exclusivity, apart from a conceptualization of Christianity as the only true religion, is that salvation cannot be offered in other denominations and religious groupings. This is similar to a historical teaching of the Catholic Church which states that *Extra ecclesiam nulla salus* (outside the church, there is no salvation).

To practice this model in the hospital means that a caregiver has to reject patients of other faiths, preach to convert them and refuse genuine communication. Engelhardt refers to the parochial model as a “traditional Christian hospital chaplaincy” (2003:145). He lists the major functions of the parochial (traditional) model as:

- i). Helping patients to recapture right beliefs in their spiritual struggle
- ii). Helping patients in rightly worshipping God
- iii). Assisting physicians in the proper use of medicine and medical sciences and
- iv). Aiding physicians, nurses and hospital administrators to act with norms of right worship, right belief and right conduct (2003:145-146).

All the professions in the hospital, through this model, are encouraged to follow spiritual/religious norms instead of healthcare norms in conducting their work. This model encourages and sustains patients in crisis by preaching to them and encouraging them to repent of their sins, but only if they are affiliated to the care provider’s religious denomination.

3.7.1.1. The advantages of the Parochial Model

The parochial model is as old as the history of Christianity. It engages many people in pastoral caregiving since it does not require any special training but only the goodwill of the people involved. Marshall (cited in Agbiji, 2013:231) is in agreement, arguing that people in general need not be taught how to provide care to patients in hospital. The Christians who are involved in this model are usually from the same community as the patient, hence they have the ability to reflect and reconstruct the particular issues affecting the patient. The community interaction gives them a chance to share common beliefs and values with the patient.

Another of this model’s strengths is that it places Christ at the centre of care. As such, caregivers preach the gospel of Christ and share the word of God with the sick, encouraging them to repent and follow Jesus, the only way to the Father. This model encourages the patients to believe that they will be healed, reconciled and will be forgiven by God through Jesus Christ (Agbiji, 2013:231). It also confirms the views of some scholars in pastoral care that at all times,

the church has responded to any type of illness through care and the provision of rituals like the sacrament of communion (Louw, 2008:522; Dunlop, 2012:32). Furthermore, this model provides certainty as pastoral care providers need no special training or preparation in order to interact with patients with whom they already share a faith. Hence there is no chance of misunderstanding between the patient and the caregiver.

3.7.1.2. The disadvantages of the Parochial Model

While the parochial model is ideal for a community belonging to the same denomination, it cannot be relevant in a pluralistic hospital environment. As Orton points out (2008), the only beneficiaries of this model are the patients who have the same faith as the caregiver who, in turn, neglects all people who have a different profession of faith. Patients who share the caregiver's religious faith, but have a different doctrinal persuasion may also be left out of the provision of care.

The emphasis placed on Christ as the only way to salvation also shifts the purpose of proper pastoral care provision. In the process of caregiving, such an emphasis foregrounds evangelisation instead of care (Farris, 2009:181). Farris further states that "the need to defend their identity, beliefs and the numerical growth of religious communities brings hatred among people and makes it difficult to provide pastoral care to patients of other faiths in the hospital" (2009:181). Such intolerance and exclusion of patients of other faiths is illustrated in the discussion on the policy document in Chapter Two. Pastors are excluded from the healing ministry of mental patients in the hospital which belongs to the RCC. Patients and their guardians are at the receiving end of the discrimination policy, yet when people are sick, they do not care where their healing comes from (Dube, Shoko, and Tabona, 2011:184).

Voicing her disapproval of the parochial model in Nigerian hospitals, Agbiji argues that the aim of pastoral care giving "should not be to get patients to repent or convert to a particular religion, but instead to allow them to experience the presence of God, his love and acceptance of their suffering through a non-judgmental and compassionate pastoral caregiver" (2013:233). Despite the differences that exist, love directs all people, especially caregivers, to be there for someone in need (Schmidt and Egler, 1998:249).

3.7.2. The Professional Model

This model is applicable to hospital setups in which professionally trained (CPE) people perform pastoral care. It “responds to the needs of all the patients in the hospital without considering their religious background or denominational affiliation” (Orton 2008:7). This type of caregiving demonstrates a movement from being denominational based to a public interfaith domain where even non-believers become the subject of care. The professional model of care comes as a direct result of the communal contextual and intercultural pastoral care paradigm discussed in 3.4.3 above. This model demands sensitivity and calls upon caregivers to pay attention to the cultural, spiritual and religious differences of patients in the hospital environment. Japhet Ndhlovu agrees that pastoral care provision in African hospitals should not focus on the patient’s faith alone but rather put together different resources and strategies in order to achieve a positive outcome (2008:225).

The reason for such an interfaith approach, as argued by Carey, Davoren and Cohen, is that pastoral caregivers have an “obligation to respond equally to the needs of people of any faith and to ensure that people of all religious/spiritual beliefs have the right of access to religious/spiritual care” (2009:203). In addition, Agbiji (2013:229) argues that all patients in the hospital are equal in the state of their sickness and as such, “they all desire a certain closeness to and similar help from God”. Patients have common shared needs like love, hope, creativity, forgiveness and need to find meaning in life. These needs should propel the caregiver to attend to all patients, regardless of their beliefs. Schmidt and Egler (1998:244) argues that “despite the fact that patients are in the hospital, the paradox and the reality is that these patients are lonely.” Since the hospital environment becomes strange to patients (Louw, 2008:209), it is the responsibility of the pastoral caregiver to make the patients feel at home again through his or her companionship.

In order for pastoral caregivers to relate to people who do not share their faith, Schmidt and Egler (1998:247) promote inclusive and pluralistic models instead of an exclusive one. In this case, the primary goal of the caregiver in the professional model is “to provide patients with their spiritual and psychological needs and not necessarily the word, repentance, conversion and salvation” (Engelhardt, 2003:149). Furthermore, Engelhardt states that the goal and principles of the professional model in the hospital is for the pastoral caregiver to “let the patients live their lives of faith without interfering with them, respect their religious beliefs,

encouraging the appropriate use of medicine, helping doctors, nurses and administrators of the hospital in providing healthcare that respects all beliefs of faith and discouraging professionals from imposing their views on others” (2003:147-148).

In the professional model, the pastoral caregiver’s faith identity should not have to interfere with good practice. In the hospital setup, professional caregivers should act like a hub in that they offer ecumenical care to everyone while uniting patients, if possible, regardless of their respective denominations and religious groupings (Engelhardt, 2003:150).

3.7.2.1. The advantages of the Professional Model

The discussion above shows that, in this model, the pastoral caregiver makes available his/her services to patients irrespective of their religious affiliation. The CPE training enables the pastoral caregiver to have knowledge of the profession, skills and dedication to his/her duty. In other words, the pastoral caregiver thinks in many ways while offering services in the hospital: ethically, historically, intuitively, empathically, interpersonally and systematically (Glaz cited in Agbiji, 2013:233). Owing to his/her specialised training, the pastoral caregiver in this model works very well with healthcare professionals in the hospital (Orton, 2008:115). During their training, the pastoral care provider is equipped with knowledge of the healthcare profession that enables them speak and understand the medical language. In such cases, the medical personnel in the hospital value pastoral caregivers as allies in the provision of health care to and the healing of patients.

The other strength of this model is its advocacy for patients’ needs. Attending to patients’ needs becomes a priority. The professional pastoral caregiver discourages health professionals from imposing their views on patients in spite of their suffering, sickness and vulnerability. This model then goes a step further than just providing therapy to patients, it also takes up issues of empowerment, liberation and development on behalf of the patients (Agbiji, 2013:233). Lastly, by not committing itself to a particular denomination, the professional model provides inclusive care in line with the principles of the kingdom of God where all are called, accepted and treated as equals, emphasizing the foundation and context of pastoral caregiving to patients in the hospital (Engelhardt, 2003:153).

3.7.2.2. The disadvantages of the Professional Model

Firstly, owing to its emphasis on training and professionalization, the professional model limits the number of people who take part in the provision of pastoral care in the hospital. This contradicts the philosophy of *Ubuntu* wherein the community is key to an individual in both suffering and jubilation. Daniel Susanto (1999:144) points out that “apart from decreasing the number of people involved in pastoral care, the professional model has taken away other functions of the faith community like teaching, preaching and worshipping.” Hence, Susanto encourages churches to train more lay people in CPE so that there can be more pastoral caregivers in the hospital (1999:150).

Secondly, in this model, the detachment of pastoral caregivers from their respective denominations puts them in an ambiguous position in terms of their religious identity. This scenario, as Agbiji argues, “has led to the downplaying of the scriptural resource and less use of it” (2013:234). Leah Dawn points out that caregivers have to give up their identities and convictions when praying with people of other faiths. Caregivers need to recognize, acknowledge and appreciate the differences in other people’s beliefs (Bueckert, 2009:148). Schmidt and Egler agree, arguing that “respecting other religions whilst maintaining one’s own religious identity entails the acceptance of certain limitations for interreligious pastoral care”(1998:252). Abandoning identification with one’s denomination or religious affiliation is equal to self-exclusion and makes a direct contribution to the destruction of that particular denomination (Schneider-Harpprecht, 2003:98). Neither the different paradigms nor the models of care directly addresses the problem of pastors’ exclusion from the provision of care at Saint John of God Mental Hospital, which is the main concern of this study. This calls to attention the need for further discussion in order to find appropriate ways of pastoral care provision which are inclusive and act in the interest of the mental patients. For this reason, I now turn to the hermeneutical approach.

3.8. The Hermeneutical Approach

The preceding discussion outlines the advantages and disadvantages of both the parochial and professional models of pastoral care. Unlike the professional model, the parochial model seems to have more limitations in a hospital setting where people of different creeds come to receive care and healing. These limitations show that a single model of pastoral caregiving is not

appropriate in today's hospitals, let alone in the current religious landscape where pastors attract Christians from different denominations because of their message of healing. As I pointed out earlier on, Saint John of God Mental Hospital has a professional chaplain who is part of the clinical team. Though other pastors are excluded from the delivery of healthcare, patients and their relatives still seek their services after they are discharged from the hospital. As such, a single pastoral care model is not responding adequately to the needs of the people suffering from mental illness at Saint John of God Mental Hospital.

This study therefore suggests that an appropriate way of dealing with pastoral care at Saint John of God Mental Hospital is through the utilisation of the hermeneutical approach. As I pointed out in Chapter One (1.10.1), Osmer suggests the hermeneutical approach because of his conviction that good ministry to people is not a matter of solving their problems, but of venturing into their world and exploring those problems with them (2008:x). In the exploration employed by the hermeneutical approach, the African understanding of illness and healing may find a space and be utilised accordingly. The fact that people suffering from mental illness view the cause of their illness as supernatural may mean that solutions to their healing have to be explored in line with their understanding.

As a researcher, I do understand that the hermeneutical approach is used in different disciplines and carries different meanings. In this study, I use "hermeneutical" to indicate a flexibility of method that adapts to a particular context, depending on the existing needs. In this way, the hermeneutical approach gives rise to many opportunities by employing different methods rather than sticking to a single model of care. The suggestion this study is making therefore aligns itself with Louw's definition. According to Louw (2012:41-43), a hermeneutical approach is holistic, concrete and less abstract as it focuses on the experiences, perceptions and emotions of the people in question. Agbiji argues that an approach, unlike a model, "is inclusive and not exclusive, allows for principles rather than a specific formula and is explorative rather than definitive" (2013:255). A hermeneutical approach then considers the complexities of human beings, their circumstances, contextual conditions, their needs and situations in order to determine how to best engage in the provision of care. Another benefit of the hermeneutical approach is that it helps to recognize that the solution offered in a specific context is not an absolute and final interpretation of all other situations, but has to be engaged "in dialogue with other minds" (Joda-Mbewe, 2002:19). In this regard, the hermeneutical approach, according to Brown's analysis (2012:120), is not conservative but liberal in the sense that it can be

questioned and corrected, refined and integrated into a system. The hermeneutical approach, because of its flexibility, would therefore be appropriate in proposing a responsible way to include other pastors in the sustainable healing of mental patients at Saint John of God Mental Hospital. It offers possibilities and options to interpret the current context and engage in dialogue with those concerned in order to come up with a workable solution. Again, the approach would give room to explore how the African epistemology of illness and healing, especially in the area of mental illness, could be integrated.

Thesnaar also argues in favour of the hermeneutical approach in stating that practical theology is in its very nature is hermeneutical as it is concerned with understanding (Thesnaar, 2013:28). He further states that “hermeneutics is a process that involves the interpretation of the meaning of interaction between God and humanity, the edification of the church and becoming engaged in the praxis through communities of faith in order to transform the world or to impact on the meaning of life” (Thesnaar, 2013:28). As a branch of practical theology, pastoral care at Saint John of God would serve people better if it utilized the hermeneutical approach which “is always guided by the moment of praxis” (Demasure and Müller, 2006:416).

While the hermeneutical approach seem to be a very creative way of providing care, as this study suggests, Demasure and Müller offer a critique in arguing that the hermeneutical approach can be abused as it does not take a formal position in between the foundationalist and non-foundationalist approaches (2006:416-417). The two seem to argue for postfoundationalism which, according to them, “positions itself firmly opposite both of these paradigms. It even goes one step further and argues for a very specific view of understanding: namely an understanding, which not only includes the local context as one of the hermeneutical circles but an understanding that can only develop within and from a local context” (Demasure and Müller, 2006:417). All in all, a hermeneutical approach allows all caregivers to be interested in listening to the real life stories of people who are struggling with mental illness in their specific and concrete situations. A hermeneutical approach would motivate caregivers to find creative ways of providing care that would be relevant to the situation at hand. This can only be possible if a hermeneutical approach of care is adopted, as this study is suggests. Having discussed a hermeneutical approach and proposing that it be adopted for pastoral care at Saint John of God Mental Hospital, I want to end this chapter by looking at the contributions made by pastors in other hospitals with a view of advocating good practice (Osmer, 2008:152) as one of the dimensions of the normative task of practical theology.

3.9. Pastors' Contributions in Other Hospitals

The main focus of this section is to portray the specific contributions made by pastors to the ministry of healing in hospitals. So far the discussion has shown that pastors take care of the spiritual needs of patients, which is a major concern when one is sick and in pain (Schneider-Harpprecht, 2003:96). In her review of health laws in Indiana, Stacey A. Tovino (2005:71) states that “at best, the hospitals consider a chaplain as a member of the medical team and at worst not as a member but someone who is moving between the world of health and religion.” She finds that “chaplains interact with patients and families, medical and nursing staff members, ethics committees and institutional review board members, hospital administrators, volunteers and community members” (2005:69). Similarly, Orton documents the following as chaplains’ core activities: “religious functions, counselling, supportive and spiritual functions for patients, families, and staff, as well as, professional functions directed to the organisation, management and staff” (2008:117). Cobb (2005:23) likewise argues that hospital chaplains meet the spiritual needs of patients, carers, staff and students. While the roles and contributions of pastors to the hospital highlighted above are rather general, this study looks specifically at the contributions made by pastors in service to patients, their guardians/relatives/visitors, staff members and the hospital as an institution. Some of the pastors’ roles and contributions cut across all the recipients of their care. As mentioned in the discussion of the policy document in Chapter Two, the specific duties and responsibilities stipulated in the job description of the Pastoral Care Coordinator at Saint John of God Mental Hospital contains some of the elements that are discussed below.

3.9.1. Pastors' Contribution to Patients Healing

Hospitals and healthcare professionals exist to help patients attain healing when they are frail and sick. Both permanent staff and supporting staff members are there to help the patient recover from illness. It is in this same vein that pastors contribute to the spiritual healing of patients. Tovino (2005:69-73) discusses the contributions made by chaplains to the hospital today through the lens of their roles and functions. She recognises that “hospital chaplains perform many functions and services that are partly or mostly religious or spiritual in nature as well as several other functions that cannot be characterised solely by their religious or spiritual

characteristics” (2005:69). The following are some of the specific contributions made by chaplains (Tovino, 2005:69-70):

- They conduct spiritual assessments of patients
- They provide spiritual care
- They perform patients risk screenings through the identification of patients whose religious or spiritual conflicts may compromise their recovery or adjustment
- They chart spiritual care interventions in patients’ medical records
- They protect patients from unwelcome forms of spiritual intrusion
- They offer an emotionally and spiritually ‘safe’ environment in which patients can seek counsel and guidance
- They assist in resolving conflicts between patients, between patients and their family members or between patients and the doctors or nurses
- They refer patients to other healthcare providers, patient advocates and social workers for help and support
- Chaplains participate in medical rounds and conference discussions regarding patients’ care

3.9.2. Pastors’ Contribution to Medical Staff

Chaplains are key in assisting the medical staff at hospitals. Such staff include clinicians, doctors and nurses and supporting staff. Medical staff consult chaplains when they experience challenges concerning their families, careers, finances and relationships. Chaplains interact with the nursing staff in the process of providing spiritual care to them. Apart from spiritual care, chaplains also facilitate communication between staff members and help to resolve conflicts between staff members (Tovino, 2005:69).

3.9.3. Pastors’ Contribution to Guardians, Relatives and Visitors

General visitors as well as patients’ relatives and guardians are some of the people who spend significant amounts of time at the hospital as they cheer and support patients. These people

have spiritual issues and questions resulting from the illness of someone close to them. As such, chaplains also interact with family members, volunteers and community members in the process of providing spiritual care (Tovino, 2005:69). They engage in communication with these caregivers when they get weighed down with the diagnosis and prognosis of a relative. As in the case of patients and staff members, chaplains also resolve conflicts between patients' relatives and guardians. Furthermore, "chaplains assist the families in executing or completing advance directives" (Tovino, 2005:69). In the event that a relative has passed away, it is the pastor who meaningfully accompanies the relatives in their grief (Tovino, 2005:69).

3.9.4. Pastors' Contribution to the Hospital Institution

Hospital chaplains do not limit their services to those which are directly defined as spiritual or religious in nature. They also provide a range of administrative, supportive and therapeutic services, making their work resemble that of a psychiatrist, psychologist, psychiatric nurse, social worker or patient representative (Tovino, 2005:70). They have so many functions and duties that they offer to the hospital institution. According to Tovino (2005:69-70), some of these include:

- interacting with the ethics committee review board and hospital administrators
- reminding the hospital workforce and patients of the healing power of faith
- facilitating spiritual biomedical issues relating to organ transplant and tissue donation
- designing, leading and conducting all religious ceremonies such as worship, ritual prayers, scripture readings, meditation, the observance of holy days, blessings and sacraments, memorial services, funerals, birth rituals, etc.
- making different academic presentations concerning spirituality and health issues
- training and supervising pastoral care volunteers from different religious communities
- conducting CPE for seminarians, clergy, laity and some religious leaders
- developing congregational health ministries
- educating students in the healthcare professions regarding the interface of religion and spirituality with medical care

- being involved in the promotion of research activities relating to spiritual care
- providing institutional support when the hospital is going through change or crisis
- taking part in interdisciplinary education, ethics committees and review boards
- taking a leading role in clarifying policies and codes of conduct to patients, visiting clergy and religious organisations
- conducting in-service training
- interpreting and analysing cultural traditions that may have an impact on the delivery of clinical services as ‘cultural brokers’ between patients, family members, staff members and the institution
- channelling communication between the community and the hospital

The white paper²⁰ in North America acknowledges the fact that not all these functions can be performed by a chaplain (VandeCreek & Burton 2001). Alternatively, it provides ten general contributions made by chaplains to the hospital which are similar to the ten roles provided by Cobb (2005:24-25) and a good summary of the many contributions listed by Tovino (2005:69-70). Firstly, the white paper states that professional chaplains are there not to proselytise but to reach out to all beyond the boundaries of faith. Secondly, they are a powerful reminders of the power of religious faith through healing, sustaining, guiding and reconciling. Thirdly, chaplains provide spiritual care through empathetic listening. They conduct spiritual assessments of patients, give referrals, offer grief and loss care and support staff members in personal crisis and with stress related to their work. The fifth contribution that the white paper lists is that chaplains are members of a patient’s care teams. Their sixth contribution is to design and lead all religious ceremonies. Their seventh contribution is that chaplains are also members of the healthcare ethics program. In this regard, chaplains contribute to educating the healthcare team and the surrounding community regarding the relation between religion, spirituality and healthcare. As such, chaplains are mediators between groups of people and reconcilers of warring members. According to the white paper, the eighth function of chaplains in a hospital is that they serve as contact persons for complementary services in the hospital like music,

²⁰ A position paper representing five major professional chaplaincy bodies in North America: the Association for Clinical Pastoral Education (ACPE), the Association of Professional Chaplains (APC), the National Association of Catholic Chaplains (NACC) and the Canadian Association for Pastoral Practice and Education (CAPPE) (VandeCreek and Burton, 2001:81-97).

meditation, touch healing, etc. Tenth and lastly is their contribution to research, which is encouraged by their certifying bodies in order to promote evidence based interventions.

The standard for healthcare chaplaincy (Anon 2006) directs chaplains to be “available to patients, guardians, relatives and other people close to the patients, including staff members and visitors, at all times”. Among the thirteen roles it provides, only three are novel as the rest are similar to those outlined by Tovino (2005) and the white paper (VandeCreek & Burton 2001). These three are: to announce and protect the infinite dignity of each and every person; to act as a reminder in the hospital of the existential and spiritual side of suffering, sickness and death; and to see that the spiritual needs of people are met disregarding their cultural and religious background (‘Standards for healthcare chaplaincy in Europe’, 2006:682). The numerous roles that are put forward by these different scholars and agencies demonstrate that chaplaincy is a multidimensional occupation (Cobb, 2005:25). This also shows that depending on the context, some tasks may be emphasized more than others.

As discussed in Chapter Two, the Pastoral Care Coordinator’s job description stipulates many of the same roles and contributions as discussed above. The difference, as this study argues, lies in limiting the provision of pastoral care at Saint John of God to Catholics exclusively. A better and sustainable policy has to be proposed in order to curb the relapse rates that result from the conflicting information and advice offered to patients by the hospital, on the one side and the excluded pastors, on the other hand. If the hospital is to achieve comprehensive care of mentally ill people, a single model of care seems to be impossible in such a multifaceted community. In this sense, this study agrees with Osmer who argues that there is “no one perspective to capture the fullness of truth ... often many perspectives are needed to understand complex and multidimensional phenomena” (2008:83).

3.10. Conclusion

This chapter outlined the contributions made by pastors to the healing ministry of patients in the hospital and pointed out that the diversity of faith among people found in the hospital calls for open-mindedness on the part of the chaplain. In order to present specific roles and contributions, the chapter explained the brief historical background of the pastoral care discipline. As such, the chapter showed that the discipline of pastoral is as old as Christianity itself. As was evident from the discussion, earlier approaches to pastoral care practice worked

well during a time when many people professed the same doctrine, but owing to the growth and religious changes in the community, recent and more inclusive practices are more useful today.

The different types of pastoral caregivers who are relevant to the spiritual care giving profession were also discussed. Apart from the ordained minister, there are many different people who also offer spiritual care to patients. These people are classified as hospital visitors, volunteers or non-ordained pastoral care providers, visiting members of the clergy and clinical professional providers composed of the laity and ordained members. The four types of pastoral caregivers operate either in a parochial model or professional model. The need for such variety of caregiving led this chapter to suggest the hermeneutical approach as the best way to address the current challenges faced by Saint John of God Mental Hospital. The hermeneutical approach is flexible and open to new ways of thinking. If it is employed, the African understanding of illness and the healing of mentally ill people may find a space for engagement. In light of the enormous contribution made by pastors/chaplains in the hospital setup, as discussed in the last part of this chapter, the question remains as to how pastors can be effectively included in the healing of patients at Saint John of God Mental Hospital. The next chapter attempts to answer this question.

CHAPTER FOUR

THE RESPONSIBLE INVOLVEMENT OF PASTORS: TOWARDS SUSTAINABLE MENTAL HEALTH HEALING

4.1. Introduction

The faith healing practices with which pastors are identified remain a force to be reckoned with. Especially since patients are attracted to the faith healing prayers that they offer. And yet, the previous chapter established that pastors make quite immense contributions to the ministry of healing and that they provide much more than just healing prayers. It showed that they have to be included in the holistic care and healing of patients in hospitals. It is based on such a background that this chapter attempts to determine the most effective and responsible way to involve pastors in the healing process of mental patients and achieve sustainable healing that they offer. In its 2013-2020 action plan, the WHO recommends that faith healers should be included in the treatment and healing of mental health patients in order to achieve inclusive mental health care (Saxena, Funk and Chisholm, 2013:1970-1971). Likewise, this chapter argues that the sustainable healing of mental patients can only be achieved if pastors are involved in their care and treatment. It suggests that Saint John of God Mental Hospital should employ a responsible and feasible policy that includes pastors as allies in the delivery of mental health care. As such, it will discuss Saint John of God Mental Hospital's current faith healing ministry as well as the opportunities and challenges which pastors present to it and the areas open to collaboration, consultation and inclusion.

Louw (2004:340) argues that pastoral care as a discipline cannot be limited to the practice of a particular church. As a theological discipline, it should be practiced with the aim of establishing a relationship between God and human beings, irrespective of their denominations or faith persuasions (Louw, 2004:341). Doran (2005:39) as well as Ellis and Hartley (2004:11-12) point out that "some healthcare professionals are aware of the fact that the biopsychosocial model is not sufficient in providing holistic care and that there exists a need to incorporate different healing approaches". Likewise, this case study assumes that a single approach to care is not possible in an organisation that operates in a context saturated by pluralistic beliefs and cultures. Saint John of God Mental Hospital already recognizes the spiritual component of healing through its establishment of the Pastoral Care Department, but this chapter poses the

following questions: Can pastors of other denominations work with medical practitioners in the healing and care of mentally ill people at Saint John of God Mental Hospital? What mechanism should be put in place for these two professions to work together?

In order to discuss pastors' involvement in mental health healing, this chapter has employed both the normative (1.10.1.3) and pragmatic (1.10.1.4) tasks of practical theology. The normative task asks the question: How might we respond? The pragmatic task responds to that question by asking: What ought to be done? (Osmer 2008:4). As indicated in chapter one, the normative task relies on other disciplines of social science and theology and has prophetic discernment as its biblical image. It applies theological concepts to interpret particular episodes, context and situations in the community or congregation. The theological aspect of the normative task (Osmer, 2008:147-152) motivates this study to engage in a cross-disciplinary dialogue with the medical sciences without losing its identity. In this regard, theology and medical science can transversally share resources of rationality even while they have different points of reference. As Osmer (2008:128) states, the two disciplines can engage in a conversation since they have areas that overlap and not only diverge. Employing interdisciplinary dialogue in the caring profession suggests the fulfilment of a hermeneutical and holistic approach. Pastoral care itself views a human being as a unit, rational and social, but influenced by cultural systems and their environment. This theological understanding of a person as a unit, and the African epistemology to healing discussed in Chapter One, forms the basis of cooperation and a holistic vision of care. Again, the suggested holistic approach indicates that a single model of care is not effective in the treatment of mental patients. This is because the complexities brought about by mental illness, especially when relapse occurs, have physical and spiritual elements. A holistic model of care caters for both and calls for collaboration between resident medical staff and the pastors of other denominations, asking them to work together in order to attain sustainable healing and care at Saint John of God Mental Hospital.

The problem at hand is that Saint John of God Mental Hospital excludes pastors of other denominations from the healing ministry to mental patients. In turn, mentally ill people still access the services of these pastors once they are discharged from hospital. At this point then, I pose the following questions: What ought to be going on at Saint John of God Mental Hospital? How might God act in such a situation or context or experience? What patterns can human beings use to respond to the situation at Saint John of God Mental Hospital? What

action can the community of Christians take in response to such practices of exclusion? Such interrogation aims at finding a theological basis as well as ethical principles, guidelines and rules that would enable us to come up with inclusive plans and strategies. The following discussion on the collaboration between professions will suggest ways in how best we might respond to the non-involvement of pastors in mental health healing at Saint John of God. In this case, the section will use the pragmatic task of practical theology which asks the question: How might we respond? Osmer states that the pragmatic task “determines strategies for action that end up influencing situations positively and enter into reflective conversation coming from the responses of enacted activities” (2008:4). It is in taking up this task that leaders require critical abilities.

The chapter is divided into four main sections. The first section presents an overview of faith healing practices in order to lay a foundation for the current practices and influences related to faith healing. Following on from that, the second section explores mentally ill people and their relatives’ affinity for faith healing prayers. The third section looks at challenges that can arise when medical practitioners and pastors at Saint John of God Mental Hospital attempt to work together. These challenges are discussed with a view to finding a workable solution that allows both the pastors and healthcare personnel to collaborate. The last section employs the pragmatic task of practical theology to deal with the collaboration of these different professions in an attempt to include pastors in the healing of mentally ill people. It is in this fourth section that I make suggestions which can enhance collaboration.

4.2. A Brief Overview of Current Faith Healing Practices

Faith healing practices conducted mainly by charismatic and Pentecostal pastors place a lot of emphasis on divine healing. Such practices are based on Pentecostalism, a term that has been defined as “a holistic faith, and the belief that Jesus is a Healer in one quarter of the full gospel” (Purdy 1994:489). Given such a definition, the sick are encouraged to come forth and be prayed for in order for them to receive instant healing from God. From its early days of founding, Pentecostal faith healing pastors have had an aversion to the medical profession and medical science, since the use of medicine is seen as a sign of lacking faith in God (Moller, 1998:183). This study is not going to duplicate the history, theology and hermeneutics behind the Charismatic and Pentecostal movements which has already been presented by other authors (Moller, 1998:179-199; Theron, 1998:191-202; Herholdt, 1998:417-431). Rather, this study

wants to propose a working collaboration between the pastors and the health care personnel in the healing and care of mentally ill people. Suffice it to say that Pentecostal and Charismatic movements have three points of departure: the function of charismatic gifts emphasizing the Holy Spirit; the understanding of the church and the physical role of the body in worship; and the fourfold role of Christ in the four gospels (moral, church, physical, and political life) (Herholdt, 1998:418).

Almost all Pentecostal churches cite four major reasons for believing in divine healing (Purdy 1994:489-490): It is biblically based; the atonement of Jesus includes his healing ministry (divine healing is part of salvation); the entire gospel is for the whole person – spirit, soul and body; and sickness is a consequence of the fall of man and salvation is ultimately the restoration of that fallen world. Many Pentecostal churches in Malawi have healing as the centre and defining focus of their ministry. For example, the local media is filled with daily adverts of pastors who conduct healing crusades and pray for people to receive money which is famously called “miracle money”. Many pastors, or ‘prophets’ as they are called, have attained names that depict the power of their ministry. For example, the Malawian founder of Enlightened Christian Gathering (ECG), Shepherd Huxley Bushiri, who is based in South Africa, is popularly known as Prophet Shepherd Bushiri. In Malawi and among members of his church, he is commonly referred to as *Major I*, or *Papa*. Such reference depicts the power that his followers think he has over the negative forces of life. He is believed to perform miracles which include healing, money multiplication, and prophesying the future of his followers. Likewise, it is reported that Bishop Oyedepo of Nigeria, who is also very famous in Malawi, has performed many miracles which include “healing people with polio, helping barren women to conceive, healing people from severe constipation and even overturning doctor’s reports and recommendations” (Brown 2011:261). There are testimonies among congregants related to his healing.

Most Pentecostal denominations see healing as an extremely important element to a victorious life and the prophet who uses anointing oil to effect deliverance and healing, is always the centre of focus (Gifford, 2006:43). For such believers, a life of victory cannot be attached to ailments (Brown 2011:252). As such, believers are healed of their chronic and incurable ailments, such as HIV/AIDS, once they are prayed for. Khosaeb (2014:223), notes that those who are not healed are usually in the background because their failure to be healed is interpreted as a lack of faith. Victory over sickness or any malady, for that matter, becomes the

default settings of many of the Pentecostal churches. Apart from healing, emphasis is also placed on occupation, promotion, remuneration, business success and expansion. According to Brown (2011:261), Pentecostal worship is linked to “success” which is understood to be “motivation, entrepreneurship, acquisition of skills, sowing in faith, prophetic declaration, and exorcism”. Cephus Omenyo and Wonderful Arthur add that the “neo-prophetic pastors have a theology that is syncretic, a biblical interpretation that is literal, a strong message in their preaching of success and fulfilment in life, and they over-spiritualise issues” (2013:53-54).

In the healing of mental patients, most faith healing pastors make a biblical connection between mental illness and demons, as is made in the gospel of John. People who were close to Jesus in the episode reported in John 7:20 and John 8:48-52 stated that “indeed Jesus had a demon and He [was] out of His mind” (John 10:20). Though reference is made to mental illness in the gospel of John, the people who thought that Jesus was out of his mind were wrong. Nonetheless, in the New Testament, mental, spiritual or emotional illness is usually diagnosed as demonic possession. Gaiser (2010:134) says that “wounds and disorders that were visible were treated as a matter of cause, but internal illness or mental illness for which the cause and location were not so clear, could only be given over to God in prayer.”

While confirming that faith healing is very popular in Africa, Khoaseb (2014:3) is of the view that it is the poor people who are mostly attracted to faith healing prayers. He gives three reasons for this attraction:

Firstly, faith healers promise to heal people of all kinds of illnesses and epidemics through fervent prayers. Faith healers are powerful and charismatic personalities that command a great following as a result of their charisma. Secondly, because African culture is spirit-centred and has a high regard for spiritual powers and forces, Africans are amused by supernatural and are therefore drawn to healing phenomena, as it speaks to their reality and reference framework. Thirdly, faith healing practice is a cost free, alternative intervention strategy for managing illness, especially to the poor masses, who do not have access to specialised medical care (Khoaseb, 2014:3).

The three reasons outlined above seem to resonate with the reasons of many patients suffering from mental illness in Mzuzu. Mental illness’ chronic nature makes patients vulnerable to any type of help that would facilitate and accelerate their recovery. Malawians, like many Africans, view mental illness as being caused by human evil forces that can only be dispelled through

prayers or traditional medicine. For this reason, the promise of healing through fervent prayers remains very attractive to many patients in and around Saint John of God Mental hospital. This is also the major reason why people visit traditional healers and pastors even after receiving biomedical health care. The third reason, however, seems most applicable to the poor population served by Saint John of God Mental Hospital. Saint John of God is the only specialised hospital in the whole region of six districts with an estimated population of 2,235,400 people (Anon 2017). It can, however, only admit 39 people and has to treat the rest through its domiciliary care program. As such, the lack of specialised care in the region and the resultant long travel distances combined with rampant poverty makes faith healing seem like a better alternative.

Mental illness, as indicated earlier on, is one of the chronic illnesses that continues to pose a challenge to many Malawians. In the African circles, it is deemed to be a serious disease that usually defies diagnosis by western medical practitioners (Dube, Shoko, and Tabona, 2011:118). Consequently, much like the Karanga people in Zimbabwe (Dube, Shoko, and Tabona, 2011:41), many Malawians believe that mental illness is caused by witchcraft and healing can only be effected traditionally (Chilale *et al.*, 2017:418; Okello and Musisi, 2015:259). Furthermore, Dube, Shoko and Tabona argue that both the pastors engaged in the faith healing ministry and the seekers of faith healing believe that if the illness is caused by witchcraft, healing can only be effected by summoning the one behind the illness or through prayers of exorcism where the Holy Spirit is implored to heal the person (2011:120). Faith healers are therefore not only among the first line of care for the majority of people with an African ancestry (Bledsoe *et al.*, 2013:23), but they are a source of hope set against the chronic illnesses that continue to inflict suffering on people (Okello and Musisi, 2015:256). As such, it is common for patients who are suffering from chronic diseases such as HIV/AIDS, cancer, and diabetes to seek faith healing (Brown, 2011:261; Ibrahim and Odusanya, 2009), perpetuating the longstanding tension and antagonism that exists between medical science and religion

4.3. Challenges in Nurturing Partnership between Medical Practitioners and Pastors

Despite the enormous contribution that Christianity has offered healthcare through pastors, as discussed in Chapter Three, there has always existed antagonism between medical practitioners

in mental health services and faith healing pastors. On the one hand, psychiatrists take any reference to religion as a sign and symptom of mental illness, a stance that makes them dismiss religion in mental health discussion (Kehoe, 2009:xxi). On the other hand, religious leaders and faith healers in particular, have perceived medical practitioners “as either ignorant about religious/spiritual matters related to mental health” or as having “disrespected the patient’s and religious leader’s view of the role of spirituality in the health and healing process” (Osafo, 2016:498). Carey and Cohen argue that there seems to exist real antipathy between pastors and doctors due to the disparate training they receive at the seminary and medical training colleges, respectively (2009:353).

A study conducted in Ghana reports on the abuse that medical personnel observed in some religious sects, but also the abuse that Pentecostal pastors saw in mental hospitals as perpetrated by doctors and nurses. This created mistrust between biomedical practitioners and Pentecostal pastors which became an obstacle to the holistic provision of mental health services (Asamoah, et al., 2014). Among the cases he reports in his study, a religious group that preached the second coming of Christ kept children in prayer camps for many years. The children were abused through flogging and young girls were forced to marry older men in the church as they waited for the Parousia. The people could not leave the prayer camp out of fear that they would miss the second coming of Christ (Asamoah, et al., 2014:262). In a similar story, the pastor of a newly formed religious movement held seven families with children captive in a bush for a period of three years without access to basic amenities (Osafo, 2016:496). In Malawi, the media reported that, based on the 1 Peter 2:24, pastors told their congregants not to take the medication given at the hospital but to rely on a God who heals (Majamanda, 2017). These pastors also advised their followers not to allow blood transfusions, but instead to eat grass and inhale insecticides, claiming that that was God’s instructions (Majamanda, 2017). Such abuse as perpetrated by pastors, may indicate that some pastors have no concern for the health and welfare of their people.

In contrast, the same study in Ghana states that pastors also witnessed the abuse of mental patients in public mental hospitals. Such abuse took the form of overcrowding, physical beatings, involuntary medical treatment, arbitrary detention, harmful therapies like electroconvulsive therapy (ECT), the use of narcotics and the stealing of food meant for patients (Osafo, 2016:496). The reaction of religious leaders to such abuses in mental hospitals meant that health personnel condemned traditional forms of healing, even though the abuse

reported was not at the hands of traditional healers. It is not the purpose of this chapter to condemn or praise the practices of orthodox medical practitioners or pastors. One can, however, not ignore the testimonies of people who claim that they received healing, some through the hospital and others through prayer, while others still have not been healed by either (Osafo, Agyapong and Asamoah, 2015:332; Khoaseb, 2014:13)

Commenting on the Malawian story of pastors cheating people through faith healing prayers, as reported above, (Majamanda 2017), a person using the pseudonym “Born Again” made an online comment that says that he likes the slogan of one Clinic in Lilongwe [Malawi] which states that “they treat, but God heals”. He asserts that the Church needs to have a sound biblical teaching on healing. He further states that he is a living testimony of God’s power and that one can be healed without swallowing a single tablet given by the hospital. According to his online testimony, Mr Born Again suffered from an un-diagnosable disease for three years (May 24, 1984 to August 20, 1986). During this time, he visited all the best hospitals in Malawi as well as the best traditional healers, but none of them offered healing. He gave up on life as he grew thinner each passing day. His employers wanted to retire him from work on medical grounds. At this point, he realised that God had a plan for his life. Such a realisation made him commit his life to prayer and the word of God. He reports that in August, 1986 he was healed from his ailment after being prayed for by a visiting international evangelist, Reinhard Bonkie. Last year, when he gave this testimony, he reported that that he was still in good health, 31 years after the miraculous healing. Such narratives can encourage people who are grappling with different illnesses to put their trust in faith healing only.

Another issue that acts as a barrier between faith healers and mental health practitioners, is the insistence on and violation of professional boundaries. In this regard, it is common practice for people belonging to specific professions to make sure that they guard their profession in a way that excludes outsiders (Axelsson and Axelsson, 2009: 320). For instance, in Uganda the training of assistant pharmacists and assistant nurses faced opposition from the professional council of pharmacists and the nurses and midwives council of Uganda, respectively (McPake and Mensah, 2008:870). Likewise, in many African countries, there is an ongoing battle between midwives and Traditional Birth Attendants (TBA’s) as many women prefer TBA’s because the services are more personal (Yakong *et al.*, 2010:2435). Saraceno and colleagues also report that a decision by the government of Brazil to train general medical doctors to work as psychiatrists in rural districts was resisted by the medical council (2007:81). In the same

way, the medical profession is opposed to neo-prophetic religious pastors who propagate faith healing prayers that promise instant healing (Osafo, et al., 2015a; Osafo *et al.*, 2015b). Most health professionals receive rigorous training, are certified and belong to professional bodies which check their performance and provide them with Continuous Professional Development (CPD). This is not usually the case with many of the pastors especially in the faith healing ministry (Asamoah, et al., 2014:608-609). As such, tension, suspicion, and the demarcation of boundaries between health professionals and religious leaders are the order of the day.

Professional knowledge regarding the aetiology, diagnosis and treatment of mental illness is therefore another area in which pastors are lacking (Osafo, et al. 2015; Osafo, 2016; Asamoah, et al. 2014). An awareness that the pastors who may be actively engaged in ‘treating’ people with mental illness may not have any formal training, hinders professional medical practitioners from engaging in collaboration (Ssengooba et al. 2012). Joseph Osafo argues that “the self-made and self-acclaimed prophets often with low education, cannot be compared to health professionals with their rigorous training” (2016:497). In support of such a statement, a study in Ghana shows that none of the 12 pastors who participated in a study that explored the nature of treatment given to mental patients by neo-prophetic pastors had any formal and organised theological training (Osafo, Agyapong and Asamoah, 2015:327). The view that most neo-prophetic pastors have low educational background is also shared by other scholars in earlier studies from Ghana (Gifford, 2006; Asamoah-Gyadu, 2005). Likewise, there are many pastors conducting faith healing prayer camps and running different denominations in Mzuzu with no umbrella body to check their credentials or to control their activities. Sociologist, Max Assimeng, has described a similar religious landscape in Ghana as “a zoo” because it has no one to control or question the activities of these pastors (1999). However, mental patients hold both pastors and medical personnel in such high regard that neither’s input can be questioned, despite differences in their understanding of mental illness (Ssengooba *et al.*, 2012; Donkor and Andrews, 2011:109).

Pastors’ perpetuation of the stigma surrounding mental illness acts as another obstacle to their collaboration with health personnel. Studies conducted in Nigeria revealed that most pastors viewed mental illness as a punishment for sins, hence mentally sick people are discriminated against (Igbinomwanhia, et al., 2013:199). The notion that the perception of mental illness as having a supernatural cause leads to the discrimination and condemnation of patients is also shared by Osafo and his colleagues in a study conducted in Ghana (2011:489). Onyina argues

that in Pentecostal circles, “every misery has a diabolical interference” (2002:107). As such, pastors advise persons suffering from mental illness to repent instead of wasting their time by going to hospital since their illness has a supernatural origin (Osafo, 2016:498). The pastor’s conviction is that something that has a supernatural and diabolical origin can only be fixed by specialised spiritual people and not by western medicine (Osafo, Agyapong and Asamoah, 2015:328; Opuni-Frimpong, 2012).

As stated in previous chapters, pastors’ advice affect the health seeking behaviour of many patients. In their study of seeking pathways and collaboration between religious leaders and professionals in mental health, Irene A Kretchy, Frances Owusu-Daaku, and Samuel Danquah report that religious leaders view health care practitioners as ignorant of spiritual matters and the significance of their patients’ spirituality in the healing process (2014:3). Likewise, the negative attitude held by medical practitioners towards alternative healing methods creates tension between physicians and pastors and prevents them from working together towards a common cause for the benefit of the patient (Kretchy et al. 2015). The importance of religion and the role of pastors in a patient’s life gives an impetus to this study, inspiring it to propose a way in which pastors and health personnel can work together as pastors are responsibly included in the healing ministry of mental patients. Agbiji argues that despite their challenges and differences, people in the caring professions have a moral and ethical responsibility towards those who are sick and suffering in the hospital (2013:275). In line with the Geneva Convention Code of Medical Ethics (GCCME), pastors and doctors or nurses should forget their differences and consider the health of their patient as a priority (cited in Campbell, Gillet and Jones, 2005:31). The question at hand then is: How can health personnel and pastors work together in the healing and caring of a mental patients at Saint John of God Mental Hospital? The section below discusses the idea of collaboration between medical staff and pastors in order to suggest ways in which they might work together.

4.4. Collaboration in Mental Health Healing: Towards the Inclusion of Pastors

The following section employs the pragmatic task of practical theology in order to suggest ways on how we might respond to the exclusion of pastors from mental health healing at Saint John of God Mental Hospital. According to Osmer (2008:4), the pragmatic task “determines strategies for action that end up influencing situations positively and enter into reflective

conversation coming from the responses of enacted activities”. This study envisages that the collaboration of health care personnel and pastors in mental hospitals will bring about better results in patients and higher levels of satisfactions among guardians and relatives. The study conducted in Ghana leaves medical practitioners with no other options, stating that “whether you like it or not people with mental problems are going to go to them [faith healers] because mental illness has been synchronized with demonic possession” (Ae-Ngibise *et al.*, 2010:558). Burns and Tomito report that half of the people in Africa who have mental health problems first visit faith or traditional healers before they seek formal health care (2015:867). The findings are similar to those that Chilale et al reported in a study conducted in the catchment area of Saint John of God Mental Hospital in Mzuzu (2017:418). Clearly such health seeking behaviour calls for collaboration between biomedical services and traditional/faith healers (Burns and Tomita, 2015:867).

A predominantly biomedical health care system has already been challenged by George Engel who suggested a biopsychosocial model as a good way of caring for patients (1977). Engel argues that “in every health care task, it is important to consider an all-inclusive approach that incorporates the patient’s biological, psychological, spiritual, and the social aspects” (1977:386). Engel further asserts the need to “broaden the perspective of healing systems in order to provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care” (1977:386). In 1977 he argued that:

[A] medical model must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician’s role and the health care system. This requires a biopsychosocial model (1977:386).

Engel’s call is not new. In 1975, two years earlier, Patrick A. Twumasi, an African medical sociologist from Ghana, had already suggested the incorporation of complementary traditional healing mechanisms to broaden health care delivery (1975). More recently, Daniel Sulmasy (2002:27) augmented Engel’s view by stating that “the approach to care should be biopsychosocial-spiritual since biopsychosocial model does not include the spiritual dimension of health”. Sulmasy’s stand point has been upheld by other contemporary scholars who put emphasis on the cultural and spiritual dimensions of sickness (Grof, 2010:742; Büssing and Koenig, 2010:19). This development in the model of care also reflects the views of Faye Belgrave and Kevin Allison who argued for the provision of a health care that is culturally

sensitive in recognizing the spirituality of the patient (2006:27). A study conducted in Eastern Kenya argues that faith healers just need to be trusted and included by healthcare workers for them to collaborate (Musyimi *et al.*, 2016:2). Studies done in South Africa (Mngqundaniso and Peltzer 2008) and Uganda (Green 2000) also show that faith healers and traditional healers are always willing to collaborate with the orthodox biomedical system but that their willingness is not reciprocated. As a result, the lack of appreciation from the medical fraternity breeds animosity and resentment among faith healers who would otherwise be willing to collaborate (Mngqundaniso and Peltzer, 2008:380; Kaboru *et al.*, 2006:2; Musyimi *et al.*, 2016:4).

In 2002, the WHO observed that when seeking healthcare, almost 80% of mentally ill Africans utilize traditional medicine (including faith healing) (2002:1). Owing to such an observation, the WHO called for an exploration and a possible engagement with Faith Based Organisations (FBO) in the healing of mental patients (WHO, 2007:4; WHO, 2006). Mental health medical workers therefore have to work with faith healers or pastors, amongst others, in order to offer a holistic and effective mental health care delivery system. Agbiji places emphasis on the importance of including a spiritual care aspect in health and healing services. She argues that religious and spiritual care “contributes towards wholeness and healing, shorter hospital stays, less nursing time, less painful medication, better mental health and a better coping process” (2013:256). Osafo, Agyapong, and Asamoah (2015:335) see an opportunity in the collaboration between orthodox treatment and faith healing through a “hope induction approach”, a strategy used by faith healers when handling mental patients. The fact that many pastors are already a source of hope to people suffering from mental illness, provides an opportunity for health promotion among religious leaders.

In considering how pastors can be included at Saint John of God Mental Hospital in order to achieve effective, efficient and holistic care, this chapter is left with questions regarding what the best approach might be. While different authors (Osafo, 2016; Chilale *et al.*, 2017; Kreindler *et al.*, 2012) McClung, Grosssoehme and Jacobson, 2006; de Vries-Schot *et al.*, 2008) suggest different forms, like engagement, consultation, integration, inclusion and cooperation, they all stress the importance of collaboration and consultation. For this reason, I will focus my discussion on collaboration and any issues that may emerge in the hospital setting. In the process of this discussion, reference will be made to other terms that have been used by previous researchers, as listed above. It is in this regard that theology can benefit from other disciplines like the medical and social sciences while maintaining its identity (Osmer,

2008:147-152). The interdisciplinary approach, when engaged properly, becomes hermeneutical and holistic, calling for a strong and positive relationship between professionals in different fields for the benefit of the patient. For, as is argued decisively by Van Voren (2010:33-35), psychiatric illness cannot be treated by one approach alone. Instead, its complicated nature necessitates a multidimensional team approach done in the spirit of collaboration.

4.4.1. The Concept of Collaboration

Barbara Gray's comprehensive definition of collaboration (1989) continues to influence many contemporary scholars. Westely and Vredenburg relying on Gray's definition that collaboration is "a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible" (cited in Wood and Gray, 1991:143). Similarly Roberts and Bradley define collaboration as "an interactive process having a shared trans-mutational purpose which is characterised by explicit voluntary membership, joint decision making, and agreed-upon rules, and temporary structure" (cited in Wood and Gray, 1991:143). On a similar note, Laura R, Bronstein points out that collaboration "is an interpersonal process that draws members from different fields in order to contribute towards the achievement of a particular goal which would not be achieved if each of those members operated independently" (2003:299).

According to Kreindler et al, collaboration can be achieved at an operational level, systematic level, interpersonal level or group level (2012:347-374). However it is done, Diane Irvine Doran (2005:39) confirms that "for quality health care to be achieved there should be proper communication, coordination, and negotiation of professionals". The concept of collaboration is also directly supported by Leviticus 26:8 and Ecclesiastes 4:12, which show that in working together people can achieve incredibly positive results. The fact that there is a close connection between the mind, the body and the spirit of a human being, necessitates collaboration of different experts in healing the same body when it is sick (VandeCreek and Burton, 2001; McClung, Grossoehme and Jacobson, 2006).

Together with collaboration, consultation is one of the terms that have been suggested above. As such, another way of engaging people of a different profession would be through

consultation in order to solve a particular problem with knowledge from outside. Consultation is defined as a “process in which a human service professional assists a consultee with a work-related problem within a client system with the goal of helping both consultee and client system in some specific way” (Dougherty, 2009:10-11). As is apparent from the discussion above, collaboration engages more professionals to act on a particular issue while consultation is an independent service between the consultant and the consultee. Collaboration is more appropriate than consultation for this study because it seeks to achieve the ongoing and responsible inclusion of pastors in the sustainable healing of mental patients.

Mental illness is a chronic disease; hence this study wants to explore areas that have to be addressed by both the hospital staff and the pastors for there to be effective and efficient collaboration. As stated earlier, healthcare personnel and pastors have different professional backgrounds (medicine and theology). As such, there is need to share knowledge in order to foster understanding of mental illness on the part of pastors and the role of spirituality in healing on the part of medical personnel (Powell, 2001:99). Such a collaboration is not a recent concept. Already in late 1920s, Mrs. Ethel Phelps, a Presbyterian lay woman, asked Dr. Slattery of Columbia Presbyterian Medical Centre “if churches which are interested in spiritual healing could help the cause by emphasizing the power of the spirit in maintaining health and abundance of life rather than emphasizing ‘curing the disease’”? (Powell, 2001:99). I will next focus on the importance of psycho-education in different professions in order to enhance mutual understanding, promote task sharing or taking shifts in hospital as well as widening the contents of the curriculum.

4.4.1.1. Mutual understanding through Psycho-education

To address the challenges stipulated above (4.3), it is of prime importance that pastors are educated regarding the causes and treatments of mental illness from a biomedical point of view. Medical personnel should also know the value of faith, hope, and compassion in the healing of those who are mentally ill. Knowledge of the treatment and healing of mental illness will allow the health care worker not only to diagnose the sickness but also to be sensitive to the cultural and religious beliefs of the mental patients. While the psychiatrist may dismiss religious beliefs as delusions, the pastor may look at the patient’s self-blame and guilt in order to give an assessment that reads it as the trigger for depression (Blass, 2001:83). If collaboration exists, both professions may benefit from the sharing of information. Blass (2001:83) observes that

the level of interaction and collaboration can only be determined by the education of pastors and psychiatrists which should lead to the building of trust between these two professions. Osafo, Agyapong, and Asamoah's findings in their recent study, present more reasons as to why the psychoeducation of pastors is important (2015). They argue that the clergy [pastors] views mental problems as a spiritual rather than a biomedical problem, hence their mode of treatment is through hope induction and prophetic deliverance without any reference to medicine (Osafo, Agyapong and Asamoah, 2015:325).

In a study examining the mental health literacy of religious leaders of Korean origin ministering in the United States of America (USA), researchers recommended mental health education and training that would enable them to respond properly to the mental health needs of the ethnic minorities who rely on pastors for their needs (Jang *et al.*, 2017:385). The researchers discovered a variation of knowledge among participants in terms of knowledge and beliefs regarding the causes and risk factors of as well as the treatment for depression (Jang *et al.*, 2017:391). It is worth noting that 41% of the study participants never referred a patient to a mental hospital for treatment despite the fact that they (pastors) were the first point of contact with these patients (Jang *et al.*, 2017:391). Although the geographical context of this study is different from the one on which I focus, the findings remain alarming in their implications for Malawi.

Owing to the nature of their training, many health care workers likewise do not really know that a vocation grounded in spirituality helps one to understand a patient better. Bruce Ambuel is firm in arguing that "there is a link between health and spirituality but many doctors have not been trained in taking spiritual history and they also do not know how faith helps in prevention, coping and recovering from illness" (2003:932). This is in line with Louw's argument that once the healing of society's structures and the dynamics of relationships among Africans have taken place, it will automatically facilitate the healing of the individual sick person (2008:41). In the hospital setup, they base their operation on evidence based research which, according to Nick Read (2006:11), "makes doctors not appreciate the meaning of illness and therefore not understand the patient fully". While spirituality is important to health and healing, as this study has argued all along, many medical practitioners still believe that faith and spirituality are not essential to the health care profession, the patient, or the hospital environment (Powell, 2001:104). One of the critiques on the inclusion of religion in health argues that "[r]egardless of what the empirical evidence is, bringing religion into medicine not

only makes no sense, it's simply wrong to do so, even if there were solid evidence – which, of course, there isn't" (Flannelly, Weaver, and Handzo, 2003:761). Though this is the case, the WHO reports that "some physicians have begun to realise the importance of faith in the healing process" (2002:7).

Another study conducted in Nigeria reveals that it is not only pastors who believe that mental illness has a supernatural cause. The study shows that more than 50% of physicians (n = 312) are convinced that orthodox medicine cannot work positively on mental illness (Adewuya and Oguntade, 2007:934). According to this study, many physicians believe that mental illness is caused by diabolic supernatural powers in the form of evil spirits, sorcery and witches (Adewuya and Oguntade, 2007:934). These findings are similar to those of another Nigeria study, though not on mental illness, which report that 50% of female doctors believed that breast cancer can only be healed through faith healing prayers (Ibrahim and Odusanya, 2009:1). These findings show how deeply embedded cultural beliefs and world views are in the practice of African physicians. As such, the sharing of knowledge between professions will certainly enhance collaboration and promote a holistic approach to the healing of mental patients at Saint John of God Mental Hospital. Admittedly, Underwood and Mosley (1991:55) argue that "the empowerment of pastors and doctors through knowledge will enhance good communication, promote a willingness to share and learn from one another, and lead to more frequent opportunities to work together for the benefit of mental patients". Malawi has limited mental health facilities and mental health personnel, yet many people are mentally unwell and need attention. Such a mutual understanding between doctors and pastors may even help on the level of task shifting, and pastors could be very instrumental since they outnumber medical personnel. But what is involved in task shifting or sharing?

4.4.1.2. Task Shifting or Sharing

Task shifting is a concept that was introduced by the WHO as a way of addressing the shortages of health care workers in third world (low and middle income) countries. The WHO (2007:7) states that task shifting is "a process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualification". It could also "involve the delegation of some clearly delineated tasks to newly created cadres of health" (WHO, 2007:7). Indeed task shifting is an emerging worldwide strategy recommended for utilization in poorly resourced countries where skills are transferred from highly specialised people to less

specialised ones (McInnis and Merajver, 2011:168). The sole purpose of task shifting is for people who are in professions other than health care to receive competence based training offered by expert clinical cadres in order for them to gain sufficient knowledge for effective use in the healing of people suffering from different kinds of illnesses (WHO, 2013). Barbara McPake and Kwadwo Mensah explain task shifting as a way of engaging non-costly health personnel who are capable of delivering the same task reliably well after a short time of hands-on training (2008:870). In this context, the study suggests that pastors would be given training in the causes and treatment of mental illness so as to contribute to the healing of mental patients. Instead of telling patients to stop taking medication (Anderson, 2009:529), pastors would encourage patients to adhere to the hospital's prescription and, at times, even refer patients for medical care. As such, the outcome of task shifting is the improvement of health care delivery and the efficient utilization of human resource in countries where numbers of health personnel are insufficient. All that is required for task shifting to be possible is basic training and continuity of support given to non-medical personnel after they become part and parcel of the health care delivery system.

The idea of task shifting is not new to Malawi. Malawi is one of the countries in Africa that are already benefiting from task shifting as advised by the WHO in the delivery of basic care packages for people living with HIV/AIDS. Non-specialist people and even some Non-Governmental Organisations (NGO's) are the ones who are at the forefront in assisting people who have contracted and are living with HIV/AIDS (WHO 2007). In the area of maternal health, the government of Malawi also introduced a one year training program for Community Midwifery Assistants (CMA) so as to boost the number of personnel assisting women who give birth (Chimbatata and Chimbatata, 2016:315). Chimbatata and Chimbatata (2016:350) further report that the government of Malawi engaged in task shifting in order to contribute to the achievement of Millennium Development Goal (MDG) four (4) and five (5) which was to reduce child mortality and improve maternal health by 2015. It was also one of the ways used to encourage women to utilize the hospital rather than traditional birth attendants (TBA). It is encouraging to note that a study evaluating the effectiveness of task shifting in four countries (Uganda, Brazil, Bangladesh, and Tanzania) found that the people who received a short training in health care work were as effective, and , sometimes even more effective, than medical personnel who received longer and specialised training (Huicho *et al.*, 2008:910). In Ghana, the program of task shifting in delivering HIV/AIDS programs which involved the traditional

leaders and pastors also proved to be very successful (Boulay, Tweedie and Fiagbey, 2008:133).

As stated previously, Malawi has very few mental health personnel and only three mental health hospitals²¹ and yet task shifting as related to mental health healing and care has not been implemented. On the one hand, there are many people suffering from mental illness. On the other hand, there are many vibrant and influential pastors. If empowered with relevant knowledge and involved in task shifting approaches, these pastors could contribute positively to the sustainable healing of mental patients. Research from elsewhere (Osafo, Agyapong and Asamoah, 2015a; Osafo *et al.*, 2015b; Asamoah, Osafo and Agyapong, 2014) indicates that Pentecostal pastors and neo-prophetic ministers are stakeholders in, not enemies of mental health care delivery. They are a source of hope, social support and health education to people grappling with mental illness (Osafo *et al.*, 2015:274). In the task shifting arrangement, pastors would refer the patients to the hospital and offer basic counselling services as well as mental health education in their churches. Osafo (2016:502) states that training pastors in mental health care is long overdue since many mental patients already visit these pastors in search of faith healing prayers. There are positive reports from Nigeria where members of the clergy who received training in mental health care collaborate very well with mental hospitals in identifying, referring, treating and healing mentally ill people (James, Igbinomwanhia and Omoaregba, 2014:569). Task shifting seems to be an immediate solution to the problem of working and engaging with pastors in the delivery of mental health care. The long term solution to working out a proper understanding that can enhance collaboration would be to add courses to the curricula of doctors/nurses and pastors on the importance of religion and spirituality and the causes and treatment of mental illness, respectively.

4.4.1.3. Widening the Curricula

The lack of knowledge among many pastors regarding the aetiology and biomedical treatment of mental illness and a similar lack of knowledge among medical practitioner regarding the connection of spirituality to mental health, calls for a long term solution. The task shifting

²¹ Of these three hospitals, there is only one in each region and two of these are run by Saint John of God Mental Hospital, one in the northern region of Malawi opened in 1994 and the other one in the central region (Lilongwe) which started functioning in 2013. The third one is the oldest and owned by the government of Malawi. It started offering psychiatric services in 1953 and is situated in the southern region (Zomba).

proposed in the previous section targets pastors and doctors/nurses who are already practicing in churches and hospitals. However, this section proposes that new students in both areas be equipped with the appropriate knowledge before they begin their work by broadening the areas of study in their respective training institutions. There is a need to re-awaken knowledge among pastors so that churches and temples can be of help in fostering mental health and not remain the sleeping giants of untapped resources that they are. The foreseen challenge with widening the curricula lies in the fact that some pastors do not attend any formal training before they start the ministry. However, the current set up in which no theological college in Malawi offers a course that addresses the issue of mental health does not provide long term solutions. Similarly, there is no course in nursing colleges and medical training schools that is geared towards teaching the future nurses and doctors the relationship between spirituality and mental health.

Patients would be happy if all their needs are taken care of when they are receiving medical care. Harold Koenig argues that patients would be very happy if their healthcare provider not only talked to them about their values but also appeared to be supporting their spiritual beliefs (2008:13). Similarly, Osafo (2016:502) confirms that “spirituality is an important aspect of most patients’ mental health hence talking about it during hospital assessment is very important”. Unlike in Ghana, where there is lack of interest in mental health issues among health professionals (Osafo 2016), Malawi is currently running speciality programs in mental health nursing and clinical medicine and the enrolment in these programs is high.²² The government of Malawi has also included mental health as a component in its Essential Health Package (EHP).²³

In the absence of training that addresses the spiritual element of mental health, there is an urgent need to widen the learning scope of not only nurses and doctors but all the cadres that work in mental hospitals, like social workers, psychologists, counsellors, and occupational therapists. Such an expansion would assist all the professionals who work with mentally ill people to recognise the value of religion and spirituality in the healing process. The knowledge gained by these mental health care workers would assist them in making assessments and appropriate

²² Saint John of God College of Health Sciences, Kamuzu College of Nursing (KCN), and College of Medicine in Malawi have specialised programs to train more health workers in the area of mental health.

²³ An Essential Package of Health Services is a package of services that the government of Malawi is providing to its citizens in an equitable manner.

referrals to pastoral care departments. Koenig (2007:113; 2008:2009) gives some of the reasons as to why all health care workers should pay attention to the spiritual needs of their patients. He says that

- i. many patients have a religious preoccupation and may want the people who are caring for them to address their religious needs
- ii. religion plays a big role in how someone copes with illness
- iii. medical outcomes may be influenced by the patient's religious belief and practices
- iv. the hospital environment isolates the patients from so many things including sources of religious help
- v. patients' religious practices and beliefs influence their medical decisions

The best time for health care workers to engage patients' spiritual needs is during the documentation of their medical history, while praying with them, or if need be, when referring them to chaplains from their respective faith communities (Koenig, 2007:113). Nancy Kehoe (2009:7-8) argues that mental healthcare workers need to take religious beliefs and the voices that patients hear seriously instead of viewing them as delusions. A culturally sensitive education for health care providers requires that they be conversant with and explore further their patients' beliefs.

Osafo argues that training in mental health and spirituality will help all the people working in the hospital environment to assess patients' spiritual needs and refer them for chaplaincy or pastoral care services in the event that there is a need or a spiritual crisis (2016: 503). Widening the curriculum for pastors specifically, might also reduce stigma and increase knowledge and understanding, which could improve mental health care and treatment and, overall, lead to more positive outcomes (Osafo 2016:504). Supplementing the need for training, Koenig also states that chaplains or pastors should be involved in care and treatment if a patient's religious beliefs are unhealthy or dangerous(2007:33). As such, pastors can be collaborators in the healing of mental patients rather than side-lined outsiders as is currently the case at Saint John of God Mental Hospital.

An augmented curriculum, both in theological and nursing/medical colleges, may make room for discussions regarding the epistemology of illness and healing in Africa. Such knowledge will give future pastors, doctors and nurses a deeper cultural understanding of the link between

spirituality and mental illness. In so doing, it will enable them to more easily acknowledge and appreciate the role that other people can play in the healing and care of people struggling with mental illness.

4.5. Conclusion

This chapter employed the normative (what ought to be going on?) and the pragmatic (how might we respond) tasks proposed by Osmer to discuss the responsible involvement of pastors in the healing of a mental patient at Saint John of God Mental Hospital in Mzuzu. The current policy and practice excludes all faith healers from interacting with mental patients at the time they are admitted at the hospital. However, mental illness is chronic, isolating, troubling, dehumanising, and one cannot fail to consult people who are offering hope in such circumstances. For this reason, faith healing pastors – who assure people that all their problems will be resolved once they are prayed for – are often consulted once patients are discharged from hospital, at which point they offer conflicting advice. Looking at the influence that these pastors have in the community in general and on mental patients and their guardians, specifically, this chapter has proposed ways of and mechanisms for including pastors in the healing ministry at Saint John of God Mental Hospital.

Charismatic and Pentecostal denominations are usually the ones involved in organising prayer camps which welcome anybody who is sick and desires healing. Healing is the central theme that attracts people from all walks of life and the pillar that assures the survival and flourishing of these denominations. While studies in which patients participated show that not all are healed, studies which interviewed pastors indicate that faith healing prayers have a 100% success rate. Clearly then, not all patients who seek healing through prayer are successful, despite pastors' assurance that they are healed in the name of Jesus. Nonetheless, many people are still attracted to these services.

People who suffer from mental illness seem to be more attracted to faith healing prayers than any other group of people suffering from illness. The reason is that mental illness is conceived to have a supernatural origin that cannot be addressed by a biomedical approach. A problem that has diabolical origins can only be healed by a pastor through the intervention of the Holy Spirit. Unlike in the hospital, where patients are alone, pastors provide a human touch through

their concern and availability to the patient and his/her relatives. This explains why mental patients are attracted to their services.

The chapter has further discussed the challenges that hinder collaboration between orthodox practitioners and faith healers. Most of these challenges centre on mistrust and suspicion. Doctors and nurses think that faith healers abuse patients and the same is true of faith healers who mistrust medical practitioners. Education levels is another area that prevents collaboration in the sense that most faith healers are seen to be uneducated. Owing to the perceived lack of education, healthcare workers put up boundaries that guard their profession from intrusion by faith healers.

Inspired by the patients who are usually confused by conflicting messages from these two fronts, this chapter has discovered that a biomedical approach alone is not a viable or sustainable solution to treating mental illness. As such, collaboration is needed so that pastors can be included in the delivery of mental health care at Saint John of God Mental Hospital. I have further discussed the steps that have to be taken for efficient, effective and smooth collaboration to take place. These steps have been proposed by the WHO as well as different academicians, mainly from Ghana and Nigeria. They propose that for collaboration to be effected, there is a need for mutual understanding. This can be achieved through psychoeducation which will teach doctors and nurses about the value of spirituality in mental health care while pastors will have access to knowledge on the causes and treatment of mental illness from a biomedical point of view. In the wake of such mutual understanding, the hospital can engage in task shifting where some responsibilities, like identifying and referring patients for treatment, could be handed over to pastors as a short term solution. As a long term solution, the chapter proposes a widening of the curricula, both in medical schools and theological colleges, to include courses in spirituality and mental health and the causes and treatment of mental illnesses, respectively. The aim of such a broadening of the curriculum is that students should be exposed to issues affecting mentally ill people before they enter employment.

On the whole, this chapter has argued for the inclusion of pastors in the delivery of mental health care at Saint John of God Mental Hospital. Utilizing the pragmatic task of practical theology, the next chapter suggests ways in which we might respond to the policy of excluding pastors from the healing ministry to mental patients. As such, it concludes this research project by presenting suggestions and recommendations regarding the inclusion of pastors to the

management of Saint John of God Mental Hospital with the hope of improving mental health delivery.

CHAPTER 5

EVALUATION, RECOMMENDATION, CONTRIBUTION AND CONCLUSION

5.1. Introduction

This chapter offers recommendations for the effective and sustainable involvement of pastors in the healing ministry of mental patients at Saint John of God Mental Hospital in Mzuzu, Malawi. It concludes and summarises what has been a library based study utilising secondary material available in the public arena, by reviewing the topics discussed so far as well as the research question, hypothesis and study objectives, before making deductions and recommendations that might improve mental health care and service delivery. It also makes suggestions regarding areas that require further investigation and study. In order to do this, chapter five utilises the pragmatic task of practical theology (1.9.1.4) to suggest ways in which Saint John of God's management team might respond to the policy of excluding pastors from the healing ministry to mental patients. The importance of the pragmatic task is that "it offers models of the practice and rules of the art which helps leaders acquire a general picture of the field they are involved in and ways in which they may use so that they reach the desired goals" (Osmer, 2008:176). Richard Osmer states that "rules of the art are specific guidelines about how one can carry out particular actions and practices" (2008:176). By employing the pragmatic task, leaders are implored to come up with appropriate and desirable methods and solutions that can effect change in an organisation.

As alluded to in Chapter One, both Saint John of God Mental Hospital and the excluded pastors are called to embrace a spirituality of servitude for the benefit of people struggling with mental illness. The innocent and vulnerable mental patients suffer the consequences of the competition and antagonism that exists between Saint John of God Mental Hospital and these excluded pastors. Such a power struggle between leaders frequently results in the relapse of patients who end up being re-admitted or, in extreme cases, dying. Both parties should realise that:

[T]he Lord is a servant, and the servant is the Lord. Power and authority are redefined. A reversal takes place. Power as dominion, or as power over, becomes power as mutual care and self-giving. Power as seeking one's own advantage

becomes power as seeking the good of others and the common good of the community. (Osmer, 2008:191)

A leader who has a mind to serve his or her people empowers them to grow and experience spirituality according to the life and teaching of Jesus who cared for everybody's needs. Jesus crossed boundaries "to bring God's love to those who were not among the 'good people' of Israel: the sick, the marginalised, the poor, and the corrupt, like Zacchaeus" (Osmer, 2008:178). For this reason, Osmer refers to such leaders as "servant leaders" and argues that the servant leader who engages the pragmatic task can actually lead an institution into the process of change (Osmer, 2008:179).

5.2. The Key issues in Previous Chapters

The first four chapters have the following points of argument:

- Liberation theology serves the concerns of poor people living on the margins of society and shows God's love for all people, including the mentally ill.
- The RCC is not alone in attempting to create a better society for people. This realisation should make the church consider including people of other faiths and beliefs.
- The concept of inculturation (the gospel being enfleshed and embodied within the paradigm of a specific local culture, without losing the awareness of multicultural pluralism) gives mandate to all missionary organisations to value the local culture where they are offering their services.
- There is a sense of a traditional African understanding of illness that determines how the mental patients at the hospital and their guardians go about finding solutions or healing. As it emerged from some of the studies, illness is presumed to have a supernatural cause. As such, illness is accredited to the active intervention of a certain human, non-human or mystical agent. Illness also affects not only an individual, but his or her entire community. For this reason, healing has to be focused on not only the individual, but his/her relationships and society as well.
- The policy that is currently in practice at the Pastoral Care Department of Saint John of God Mental Hospital in Malawi is not reflective of the overarching Provincial or Curia policies.

- In the current setup, many people from different denominations are attracted to Pentecostal and Charismatic ministries which conduct faith healing prayers and preach a gospel of prosperity.
- The pastors have an influence on health seeking behaviour of their flock, especially on the people suffering from mental illness as well as their guardians. As such, pastors make major contributions to the healing of people in hospitals and their services cannot be denied by patients, guardians or hospital staff members.
- Pastors' exclusion from the delivery of mental health care has an impact on the lives of people suffering from mental illness. The relapse of mental patients due to instructions from pastors to stop medication has adverse effects on these patients, their guardians and family and their larger community.
- The provision of pastoral care in hospitals is as old as the concept of hospital themselves. Pastoral care provision has grown from a homogenous Christian society to a professional and now a communal contextual and intercultural model. With the emergence of faith healing prayers, a hermeneutical approach seem to be a viable way of offering pastoral care to people who are mentally ill.
- Biomedical care cannot meet all the health needs of mental patients. Understandably, the doctor or the nurse cannot handle all of the patient's needs. "It is also not practicable for a single individual or profession to take on such a vast amount of responsibility" (Hill and Smith, 2010:175). Agbiji agrees that the "medical professionals, no matter their best possible efforts, cannot in themselves remedy medical and spiritual problems" (2013:265). This calls for collaboration with other service providers, like pastors. If wider and more inclusive curricula were to be offered at their respective colleges, this would facilitate collaboration between doctors/nurses and pastors which, in turn, would lead to trust, task sharing and the proper referral of patients, resulting in the holistic care and healing of mentally ill people.

These key points show that one single model is not enough to address the needs and effect mental health healing of the mentally ill patients at Saint John of God Mental Hospital in Mzuzu. Pastors have to be responsibly included in the healing process of mental patients in order to achieve sustainable healing.

5.3. Evaluation of the Research Question, the Study Hypothesis and Objectives

This section evaluates the research question (1.6), the hypothesis (1.7) and the three objectives (1.8) that guided this study. These objectives and the hypothesis aimed to critically evaluate the involvement of pastors in the healing of people with mental illness at Saint John of God Mental Hospital in Mzuzu, Malawi.

5.3.1. Evaluation of the Research Question

This research project's question was:

How could pastors of other denominations be involved in mental health care and healing at Saint John of God Mental Hospital in order to achieve a sustainable healing ministry to patients?

The research question was based on the existing policy that excludes pastors of other denominations. Chapter Two was foundational in that it formed interrogated the challenges that the exclusion of pastors brings to patients and their guardians. The chapter discussed the policy documents and depicted some of the loopholes in the institutional practice of excluding pastors of other denominations. It was useful in answering the research question because it helped the study to argue for the involvement of pastors. Chapter Two considered the cost implications of the relapse of patients as the major outcome of such exclusion. Chapter Three presented the history of pastoral care. The historical advancement and growth of pastoral care in hospitals showed the contribution that the pastors have made towards the healing of patients. This discussion enabled me to argue for the inclusion of pastors in the healing of the mentally ill by employing a hermeneutical approach. Chapter Four suggested useful and collaborative ways in which pastors can be included in service delivery. As such, both Chapters Three and Four directly responded to the research question of this thesis. In its final analysis, the study recommends that for there to be sustainable healing at Saint John of God Mental Hospital, there must be ways of involving pastors of other denominations in the healing ministry.

5.3.2. Evaluation of the Study Hypothesis

The study hypothesised that pastors should be involved in the healing ministry to mental patients at Saint John of God Mental Hospital in Mzuzu. This hypothesis was based on the current policy document in use at Saint John of God Mental Hospital that excludes all faith healing pastors from the healing ministry to mental patients. The discriminating policy has a negative effect on patients that, in search of healing, still consult these pastors after they are discharged from hospital. During faith healing prayers, mental patients are assured that they are healed hence they should have faith in God and stop taking medication. In most cases, the stopping of medication has led to the relapse of patients who then seek re-admission to the mental hospital. As Ogbu Kalu argues, relapse and spiritual crisis follow when sick people mistakenly believe that they have been healed, only to later find out that they have not (2008:265). The study has shown how relapse negatively affects patients, their guardians or relative and their larger society. If pastors are included and knowledge is shared between the pastors and the healthcare workers, it would minimize the chances of relapse.

The study used the four tasks (1.9.1) of practical theology as propagated by Osmer (2008:4-12) to structure and organise the data and arguments used to achieve its objectives. As a non-experimental research project, it engaged in the textual analysis of published secondary data consisting of Saint John of God's policy documents as well as books and peer reviewed articles related to mental illness and pastors' contributions to the holistic healing of sick people in general and those grappling with illness in particular. Through the objectives outlined in Chapter One (1.8), this study confirmed the hypothesis that pastors have to be involved in the delivery of mental health care at Saint John of God Mental Hospital.

5.3.3. Study Objectives

The study objectives, as set out in Chapter One (1.8), presented a platform for focused work aimed at producing a measurable outcome. In line with the goal, hypothesis and the research question, this study addressed the following objectives:

- i. To determine the extent of the impact of pastors' exclusion from the delivery of mental health care at Saint John of God Mental Hospital
- ii. To explore the contributions made by pastors to health care delivery

- iii. To determine viable ways of including pastors of other denominations in the sustainable and holistic healing of patients in the hospital

5.3.3.1. The Impact of Pastors' Exclusion from the Delivery of Mental Health Care at Saint John of God

Chapter Two addressed the first of the above three study objectives. In doing so, it presented the three policy documents in use by Saint John of God Hospitaller Services. The chapter analysed the policy documents and proposed possible reasons for the exclusion of pastors, using the descriptive empirical task of practical theology (Osmer, 2008:4-12) to respond to the question: What is going on? (1.9.1.1). The analysis of the policy documents revealed that, contrary to the provisions made in the Curia and Provincial policy documents, pastors are excluded at Saint John of God mental Hospital in Malawi. The chapter further indicated that such exclusion is problematic because pastors act as gateway providers, networkers and a bridge builders in the community involved. As such, they have a strong influence on people, making them relevant to the success of any mission. However, because of their influence, the pastors' exclusion from the delivery of mental health at Saint John of God Mental Hospital often leads to relapse when they instruct patients who are discharged from hospital to stop medication in favour of faith and prayers. Such relapse and subsequent readmission has serious cost implications for the hospital and the guardians and can, in a worst scenario, result in a patient's death.

5.3.3.2. Exploring the Contribution made by Pastors to Health Care Delivery

The second objective of the study was addressed in Chapter Three. Emerging from a discussion of pastor's exclusion from the delivery of mental health care, Chapter Three showed how the pastors have been engaged worldwide in the hospital healing ministry. Since the second objective was to find ways of responsibly including pastors in the healing ministry at Saint John of God Mental Hospital in Mzuzu, this chapter utilised the normative task of practical theology in order to answer to the question: What ought to be going on? (1.9.1.3). The use of the normative task in this chapter was intended to ascertain whether pastors could be engaged in the hospital healing ministry based on what they have contributed in other hospitals. The interpretation of the normative task directed the discussion in Chapter Three to construct norms which guided the responses to and strengthened the learning of good and acceptable practices to be employed at Saint John of God Mental Hospital in Mzuzu.

In pursuing this second objective, the chapter presented the historical development of pastoral care in hospitals. The discussion in Chapter Three showed that the discipline of pastoral care has undergone different paradigm shifts at different times of its practice. The findings indicated that the classical model, the clinical model and the communal contextual or intercultural model of care have been of use in their own respect and time frame. However, the chapter proposed the hermeneutical approach as presented by Osmer (2008) and Louw (1998: 41-43) as an appropriate way of including pastors in the healing ministry of mental patients at St. John of God Mental Hospital. Through a careful analysis of the paradigm shifts, the chapter discovered that pastoral care, which is the contribution of pastors to the hospital setup, is not static. The analysis found that pastoral care is a dynamic discipline that constantly responds to historical and geographical contexts. As such, the hermeneutical approach is holistic, concrete, and less abstract in focusing on the experiences, perceptions and emotions of people. In this sense, the patient's circumstances, needs, and situation determine the approach to the provision of care. The hermeneutical approach makes room for the complexities of human and contextual conditions. The contribution of pastors in the health sector shows that faith based studies can support clinical and social sciences as well as other relevant fields in order to understand the patient better (Osmer, 2008:128). While pastors interact with other professions in the provision of healthcare, their contribution is unique as they focus on the entire person existing in a specific environment and having different relationships. In its final analysis, the chapter discovered that recent inclusive practices in the pastoral care discipline are more useful due to the growth of and religious changes in the community.

5.3.3.1. The Inclusion of Pastors in the Sustainable Healing of Patients at the Hospital

The third objective, to find effective ways of including pastors in the sustainable healing of patients at the hospital, was presented and discussed in Chapter Four. The main goal of the discussion was to propose ways of collaboration in order to achieve the sustainable healing of patients suffering from mental illness. Based on Chapter Three's discussion of the contributions made by pastors in the hospital setup, the research found it necessary to propose ways in which pastors could be included in mental health healing. To achieve this objective, Chapter Four employed the normative task (1.9.1.3) of practical theology to respond to a question: What ought to be going on? (Osmer, 2008:4). The normative task of practical theology emphasises the need to incorporate other disciplines from the social sciences and theology. It has three

dimensions: “theological interpretation, ethical norm and good practice” (Osmer, 2008:152). It was assumed that the good practice learned from other hospitals and the growth of pastoral care provision would be useful in understanding the need for the inclusion of pastors in mental health healing. This research project discovered that the dimension of good practice in the normative task may help in coming up with novel ways of conducting pastoral care and healing at Saint John of God Mental Hospital.

To achieve the third objective, Chapter Four focused on presenting an overview of current faith healing practices. The aim of this discussion was to contextualize the faith healing practice and its relevance and appeal to those suffering from mental illness. In this vein, the discussion went further to propose reasons as to why faith healing practices attract many people affected by mental illness. Since mental patients navigate between the hospital and faith healing camps in search of healing, the chapter presented anticipated challenges to the development of a working relationship between health personnel and pastors. In view of the goal of finding a workable solution to the problem of how best to include pastors, the chapter presented a deliberate discussion related to the collaboration of professions in the treatment of a mentally ill patient in the hospital. It was suggested that collaboration will require psychoeducation, task shifting and a widening of curricula in medical/nursing colleges and theological colleges.

The chapter established that pastors could be responsibly included in the healing mission of mentally ill people. Once trust is established between the doctors/nurses and pastors, there can be a good working relationship enhanced by shared knowledge. Initially, pastoral care was not a specialised ministry. In its parochial model, pastoral care in the hospital was faith based without any special skills other than those acquired for general church-based ministry. Literature has revealed the historical growth of the pastoral care practice. The historical development attached to pastoral care gives hope that pastors can be included in the healing ministry of mental patients at St. John of God Mental Hospital. Such inclusion would help to prevent relapse and would eventually lead to a smaller burden of care and a lower cost implication in treating and caring for people suffering from mental illness. The collaboration of pastors and medical personnel in the rehabilitation and healing of mental patients would consequently lead to a more successful outcome. As discussed in Chapter Four, exclusivity undermines a mode of healing that is supposed to be holistic in nature, which is why this study recommends the hermeneutical approach as discussed next.

5.4. The Recommendations

This study's findings and consequent recommendations are based on evidence based research in the field of pastoral care, practical theology and healthcare. These recommendations build on the suggestion that servant leaders are called upon to take on new challenges in order to effect positive change in their organisation, as made in the introduction of this chapter. As discussed below, they are aimed at the management and the Pastoral Care Department of Saint John of God Mental Hospital in Mzuzu, as well as the Government of Malawi through the National Council of Higher Education (NCHE).

1. An Inclusive Policy that Allows Pastors to be Involved in the Mental Health Healing Ministry

Based on the presentation, discussion and analysis of the policy document in Chapter Two, this study recommends that the management of Saint John of God should align the Pastoral Care Policy and Standards of Saint John of God Hospitaller Services in Malawi with the Curia and Provincial policy documents. In this regard, the Malawian policy document will reflect the policy recommendations of the two higher policy documents. Such alignment will enable Saint John God Hospitaller services in Malawi to update what is currently a 'one size fits all' policy document so that it might be relevant to the cultural situation of the people benefiting from its services. As such, the updated policy document in Malawi should have a sector-based approach to its pastoral care policy, bearing in mind that diverse people benefit from the pastoral care services of Saint John of God Mental Hospital. While staff members belonging to different denominations at Saint John of God Mental Hospital are included in the pastoral care team, they are not pastors and they do not have the gifts that patients seek when they desire healing. As the study established, Saint John of God Mental Hospital in Mzuzu could learn from another Saint John of God centre in Australia where the pastoral care team is composed of professionally trained pastoral caregivers from different Christian denominations.

Once updated, the pastoral care policy should include pastors in the healing ministry of the mental patient. It should also be patient centred and patient friendly in order to accommodate the needs of patients in the current religious landscape which attracts more people to the faith

healing ministry. Furthermore, the study proposes that the management of Saint John of God Mental Hospital takes the time to understand the environment in which the hospital is offering its services. As a missionary organisation, the institution might do well to understand and practice inculturation as propagated by the same Roman Catholic Church through the African Synod. The Malawian policy document indicated that all other departments except the Pastoral Care Department have localized policies. Inculturation will bring to the fore the fact that healing among people in a traditional African society is not disjointed but all-inclusive. It takes into consideration the patient's relationships and environment. Sustainable and holistic mental health healing may remain elusive as long as the pastors and cultural values of mental patients are ignored.

2. Discernment in the Pastoral Care Department

In light of the fact that the hospital has a Pastoral Care Department headed by a professionally trained Catholic Pastoral Care Coordinator, the study recommends that there should be a spirit of discernment in engaging pastors from other denominations. Osmer (2008:132-139) refers to this discernment as prophetic. He further states that “[i]n discerning what we ought to do in particular episodes, situations, and contexts, we will do well to use an explicit approach to forming and assessing norms” (2008:139). The study appreciates and recognizes the Catholic proprietorship of Saint John of God Hospitaller Services. However, in the event that pastors from other denominations have to be invited at a patient's request, as the Curia policy recommends, the coordinator should be able to discern between false pastors and true pastors. The study established that the large-scale growth of pastors/prophets in both Charismatic and Pentecostal churches opened up avenues for both false ones who are business oriented and true ones. Faith healing pastors present a challenge because they claim that they can heal any type of sickness and consequently raise the expectations of the populace. For example, a study conducted in Tanzania confirms that some faith healing pastors aim to make money rather than truly heal the sick people (Muela, Mushi and Ribera, 2000:299). It is with such a background that discernment regarding who is operating in truth is required. It must be the duty of the Pastoral Care Department to operate within the faith and belief system of the patient in question in order to find proper religious resources for healing. The Catholic identity of the Pastoral Care Coordinator should only be of importance in the event that a patient subscribes to the rituals and beliefs of the Catholic Church.

People in the Pastoral Care Department need to go the extra mile and reach out to pastors surrounding Saint John of God Mental Hospital in order to establish a conversation with them. They also need to follow up on clients and do a constant check with the guardians regarding the patient's beliefs and adherence to the prescribed treatment. The Pastoral Care Coordinator should insert himself/herself or herself in the community in order to know the pastors, reach out to their respective congregations and be involved in some of the prayer sessions. In this regard, a patient's initial assessment form should have a section on religion and pastoral care that can document meetings with individual pastors. In this way, Saint John of God Mental Hospital can establish the type of collaboration advised in the analysis of the policy document, literature discussion and the historical presentation of the pastoral care discipline.

3. Widening of Curricula in Colleges

The study showed that there is a lack of knowledge regarding the connection between spirituality and mental health among healthcare workers. There is also lack of knowledge amongst pastors regarding the aetiology and biomedical treatment of mental illness. Given these shortfalls, the study suggests that the government of Malawi, through its department of NCHE, should consider introducing a course on mental health in theological colleges and a course on spirituality or pastoral care in medical/nursing colleges. This could provide a long term solution to the research problem by bridging the knowledge gap identified above and, in so doing, fostering and strengthening collaboration between pastors and mental health care workers.

As discussed in 3.8, the widening of curricula in colleges would put into effect the hermeneutical approach. In this case, the colleges (theological, medical and nursing) would be instructing their student to be flexible in their approach to care and healing. Students need to be knowledgeable of the fact that the healing of mental patients is not a question of only knowing the cause and effect, neither is it a matter of solving their problems. Rather, it is a ministry that has to be constantly explored. Working from the basis of the hermeneutical approach will provide more room for including and accommodating the African understanding of illness and healing as discussed in Chapter One. The flexibility that comes with the hermeneutical approach will also provide a sound foundation from which to explore the best way to engage the traditional healers whom this study has shown to have influence over people suffering from mental illness. Again, it is in the colleges that students can gain knowledge

regarding the practice of inclusivity. In this regard, both pastors and health care personnel will appreciate the chance to uplift people living with mental illness as well as other marginalised people. In these new curricula, gender studies would be deliberately taught to nurses, doctors, and pastors. Students would also be exposed to aspects of liberation and queer theology which are compatible with the concerns of the underprivileged and often rejected members of society (the poor, the sick, women and children).

4. The Regulation of Pastors

The study proposes that the government of Malawi regulate pastors through the registration of religious denominations, which will guarantee accountability. The current scenario in which pastors have no checks and balances leaves room for abuse. These abuses are not only affecting mentally ill people but they also affect the population at large. Oppressed and marginalised people are vulnerable and are most likely to put their trust in pastors. There is a need for set standards that regulate the qualification of pastors, the physical location of their congregation and the theology that they are teaching to the people, before they can be allowed set up a congregation.

5.5. This Study's Contribution to the Existing Body of Knowledge

Research regarding the inclusion of pastors or chaplains in the healing of people in hospital with different illnesses has been done globally. Such studies have documented the unique role played by pastors in the hospital based healing mission. However, there is dearth of research regarding the involvement of pastors from other denominations in the healing mission of mental patients in Malawi. Different studies related to mental health in the Malawi have been conducted by medical doctors, sociologists, and nurses. They have only mentioned the influence of religion and pastors in passing. In contrast, this interdisciplinary study, conducted in the field of Practical Theology (Pastoral Care and Counselling), interacts with medical practice to argue for the inclusion of pastors in mental health healing at Saint John of God Mental Hospital.

The attraction and influence of faith healing pastors on the majority of people has an impact on the care and healing of people suffering from mental illness. As such, this case study comes at a time when many people are turning to pastors for different answers. As discussed in this

study, Pentecostal and Charismatic pastors have become a force to be reckoned with in African society and, as such, they have to be included in the mental hospital ministry in order to achieve holistic healing. Apart from being involved in caring and healing mentally ill people, pastors visit other hospitals in Malawi following old models of pastoral care. The discussion in Chapter Three opened up opportunities for the focused development of a pastoral care function in Malawian hospitals. Following on from that, the discussion in Chapter Four as well as the overall findings of this study contribute to finding appropriate ways in which to involve pastors in the health care and healing of mental patients in order to contribute to sustainable healing practices and a drop in the relapse rate of patients at Saint John of God Mental Hospital in Mzuzu. This study points out that the management teams of different institutions must think beyond religious denominations and associations when they create policies that affect the welfare of the people they are serving. For there to be an effective and efficient healthcare system, the influential members of society who have a bearing on the decisions of patients have to be engaged in the healing of those same patients. The inclusion of pastors in mental health healing shows that the perspective of pastoral care is intercultural and interfaith in nature. The worship of God in most Africa societies aims at the entire glorification of God. As such, it goes beyond time, place and structure. After making recommendations, I now suggest areas for further research.

5.6. New Focus Area for Further Research

The readings, discussion, and findings of this study have shown that there is need for more research to be done. Therefore, based on my study, I suggest the following areas for further research:

- This study was based on secondary data in the public domain, the library, online peer reviewed articles and the policy documents of Saint John of God Mental Hospital. Based on this methodology, I propose that there is need for empirically based research that engages with the pastors, the hospital administration and the patients themselves.
- The focus of this research project was the involvement of pastors in mental health healing. Further research could be done to determine how pastors could be included in the care of people suffering from chronic medical conditions like HIV/AIDS, Diabetes, and High Blood Pressure. Patients suffering from such illnesses are also targeted by faith healing pastors and end up to stopping medication. A study could also be

conducted on the place of pastoral care in Malawian hospitals. The literature consulted in this study showed that there is no study that has been conducted in Malawi related to pastoral care in the hospital setting.

- Another potential area of research would be the relapse rate of patients suffering from mental illness in relation to their denominations. Do the teachings of various denominations have an effect on patients' relapse rates? Alternatively, a similar study would look at the success rate of mental health healing methods in Malawi.
- Given the number of women who are suffering both as mental patients and the caregivers of mentally ill people, a study looking at the gendered impact of mental illness and the influence of pastors on women affected by mental illness would be appropriate.

5.7. Conclusion

This study was a critical analysis of the involvement of pastors at Saint John of God Mental Hospital. The study presents recommendations on how pastors may be responsibly included in the healing mission of mental patients. The study was conducted from a theological point of view and was based on the analysis of the policy that excludes pastors from the healing ministry at Saint John of God Mental Hospital. The fact is that pastors are influential members of society and they are consulted by patients and their guardians after being discharged from hospital. The prosperity gospel currently being preached by many Pentecostal and Charismatic pastors, as well as the healing prayers on offer, has attracted many people. As such, in order to achieve the third Sustainable Development Goal (SDG) of ensuring healthy lives and promoting wellbeing for all, at all ages (UNDP, 2015:6), pastors have to be included in the mental health healing ministry.

This study has indicated that missionary organisations like Saint John of God Hospitaller Services need to consider the cosmology and epistemology of the people they serve for them to be relevant. In this case, being a Roman Catholic Church organisation, they should contextualise the teaching on inculturation as promoted by the African Synod and the unique understanding of illness and healing held by most African patients should be taken into consideration by both the medical personnel and the pastors working in Saint John of God Mental Hospital. This study has also established that pastoral care is dynamic and reflects the

context of the place where it is practiced. As such, Saint John of God Mental Hospital will serve its patients better through pastoral care if they are up to date with the latest developments and changes in pastoral care discipline.

This study appreciates the numerous contribution made by the biopsychosocial medical model in treating patients with mental illness. However, the emergence of neo-prophetic pastors has to be addressed in order to fight the increased relapse rate among patients. This study therefore suggests that pastors are non-medical partners in the hospital set-up who can be taken on board through psycho-education, task shifting and the widening of their curricula. The provision of pastoral care in today's world could be more beneficial to patients if it was intercultural and interfaith in nature. The hypothesis that this study makes is that a good sector-based policy that includes pastors in the healing ministry of mental patients could be put in place at Saint John of God Mental Hospital.

Furthermore, based on the findings and recommendations of this study, the government of Malawi should consider finding an effective and professional way to engage pastors in the treatment and care of other chronic illnesses in hospitals. This suggestion does not negate the fact that dialogue between hospital management, pastoral care departments and the pastors themselves would be the best way to initiate the process of working together in the healing mission. As this study has established, Saint John of God Mental Hospital can no longer overlook pastors in its delivery of mental health services.

Thus the study confirms the research hypothesis that pastors of other denominations should be included in the healing ministry to mental patients at Saint John of God Mental Hospital in Mzuzu. The inclusion of pastors will increase collaboration in the healing ministry, reduce the relapse rate of patients who stop taking their prescribed medication, reduce the costs of caring and treating mentally ill people and, finally, reduce the burden of care on guardians and relatives due to frequent re-admissions. When all the related parties start working together in order to benefit the mentally ill, then the healing and recovery rates of such ill people will increase.

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